Gerrish Chiropractic Center

276 State Highway 3, Bar Harbor, ME 04609

phone: 207-288-3980 fax: 207-288-8030

email: info@gerrishchiro.com website: www.gerrishchiro.com

Confidential Patient Case History

Welcome to our office! Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. Thank you!

Name:_____**Date**:_____

Address:_____**Date of Birth**:_____

City:_____ **State**:_____ **Zip**:_____ **SSN**:_____

Home Phone:_____**Cell Phone**:_____**Work Phone**:_____

Email Address:_____

Gender: M F **Marital Status**: S / M / D / W

Emergency Contact Name:_____**Phone Number**:_____

Address:_____**City**:_____ **State**:____ **Zip:**_____

Medical Doctor Name:_____ **Phone Number**:_____

Employers Name:_____ FT PT

Address:_____ **Phone**:_____

Who Referred You To Us?:_____

_____ I wish to receive an email of my clinical summary after every visit. (**A clinical summary is a report of your office visit including diagnosis and treatment plan**) ***** please provide email above and a password of your choice below for receipt of your clinical summary*****

_____ I choose to decline receipt of my clinical summary after every visit. I reserve the right to request a clinical summary at any time.

Password for the Clinical Summary link that will be sent to your email:_____

Insurance Information:

Yes No Are you covered by a Group Health Plan through your current or former employment?

Yes No Are you covered by a Group Health Plan through your spouse or other family member's current or former employment?

Yes No Are you receiving Workers' Compensation (WC) benefits?

Yes No Are you filing a claim with a no-fault insurance or liability insurance?

Yes No Are you being treated for an injury or illness for which another party has been found responsible?

Who is responsible for this account?:_____\

Relationship to Patient?:_____ **Birth Date**: _____

Assignment and Release:

I certify that I, and/or my dependent(s) have insurance coverage and assign to Gerrish Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the doctor or chiropractic office to contact me via mail, email and phone in regards to treatment as well as promotional activities. Gerrish Chiropractic Center may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent or Guardian:_____

Printed Name of Patient, Parent or Guardian:_____

Date:_____ **Relationship to Patient**: _____

Patient Name:_____ **Date:**_____

Current Primary Health Concern

What pain causes you to come to the office?_____

What caused this pain? _____

When did this pain start? _____ **How long does this pain last?** _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other Problem

What other pain do you have? _____

What caused this pain? _____

When did this pain start? _____ **How long does this pain last?** _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain.

Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Chiropractic History

Previous Chiropractic care? Yes No **If yes, Doctor's name**:_____

Date of last chiropractic visit: ____/____/____ **Date of last chiropractic X-rays**:____/____/____

Reason for care:_____ **How long were you under care?**: _____

Were you satisfied with the previous chiropractic care you received? Yes No

Are other family members under chiropractic care? Yes No **Who?**:_____

Previous Conditions

Date of Last Physical Examination: _____

Have you sought care for another health condition in the past year? Yes No **Past 2 years?** Yes No

If yes, what condition other than your primary complaint?:_____

Was treatment administered? Yes No **Describe**: _____

_____

Do you take medications? Yes No **If yes, please list dosage, frequency and reason**:_____

_____

_____

Immunizations (Please list with dates): _____

_____

Allergies:_____

_____

Any prior hospitalizations or surgery? Yes No **Describe with dates**:_____

_____

_____

Have you been in an auto accident or had any other personal injury? Yes No

Describe:_____

_____

Family History

Indicate if any of your immediate family members (parents, grandparents, brothers, sisters, children) have had any of the following:

Check if yes:	**Family Member:**
____ Diabetes	_____
____ Thyroid Disease/Goiter	_____
____ Tuberculosis	_____
____ Kidney Disease	_____
____ High Blood Pressure	_____
____ Heart Disease	_____
____ Cancer	_____
____ Rheumatoid Arthritis	_____
____ Stroke	_____
____ Substance Abuse	_____

Patient Name:_____ Date:_____

Social History

Height:_____ft. _____in. **Current Weight**:_____ lbs. **Blood Pressure**:_____/_____

Have you recently lost or gained more than 10 lbs.? Y N

Preferred Language: _____

Race (circle one): American Indian or Alaska Native / Asian / Black of African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to answer

Exercise: Heavy Moderate Light **Hours per week**:_____ **Type**:_____

Smoking: Never Currently Previously **Packs/day**:_____, **Pack/week**:_____ **How long?**:_____

Alcohol: Beer/week:_____, Liquor/week:_____, Wine/week:_____ **How long?**:_____

Caffeine: Cups/day:_____ **How long?**:_____ **Aspirin**: No./day:_____ **How long?**:_____