



ATLANTIC CHIROPRACTIC & PHYSICAL THERAPY

Welcome To Our Office

Atlantic Chiropractic of Patchogue

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Patchogue, NY 11772
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Fax (631) 758-6379

Atlantic Chiropractic of Shirley

409 William Floyd Parkway
Shirley, NY 11967
(631) 395-7424
Fax (631) 395-7420

Patients Name _____

Reference Number _____

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

THANK YOU.

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D

Children _____ Spouse's Name _____ Referred by _____

Patients Employer: _____ Telephone _____

Address _____

PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete the questionnaire on the next page. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

1. Present Complaint: _____

2. Please describe the character of your current pain (you may check one or more answers): Sharp/Stabbing Sharp/Dull Aches Dull
 Soreness Weakness Throbbing/Gnawing Numbness Shooting Gripping/Constricting Burning Tingling

3. How often are your complaints present? Constant, (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less).

4. How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN UNBEARABLE PAIN

5. Since your problem began is the pain: Increasing Decreasing Not Changing

6. When did your problem begin: (Specific date if possible?) _____

7. Did your problem begin: Immediately after a specific incident Multiple incidents Gradually developed over time No specific reason

8. Describe how your problem began: _____

9. What treatment have you received for this present condition? Surgery Spinal injection Therapy from a PT A back support
 Medication(s) _____ Other _____ If none check here

10. Were you previously treated for a different occurrence of this same condition? Yes No If yes by: Chiropractor MD Therapist
 Other _____ (Specify dates & type of treatment with results) _____

11. What makes your problem better? Nothing Lying Down Walking Standing Sitting Movement/Exercise Inactivity
 Other _____

12. What makes your problem worse? Nothing Lying Down Walking Standing Sitting Movement/Exercise Inactivity
 Other _____

13. How would you grade your general stress level? No Stress Minimal Stress Moderate Stress Greatly Stressed

14. Physical activity at work: Sitting More Than 50% of Workday Light Manual Labor Manual Labor Heavy Manual Labor

15. General physical activity: No Regular Exercise Program Light Exercise Program Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?

- No effect
- Some physical restrictions (able to perform light duty work and household tasks).
- Need limited assistance with everyday tasks.
- Need assistance often.
- Have a significant inability to function without assistance.
- Am totally disabled (impaired). Cannot care for self.

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Depression (311)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders) (492.8)
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm (441.5)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (716.9)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure (401.9)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (250.0)
<input type="checkbox"/>	<input type="checkbox"/>	Angina (413.9)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer (556.9)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (410.9)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones (592.0)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (436)	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection (595.9)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (493.9)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (199.1)	<input type="checkbox"/>	<input type="checkbox"/>	Colitis (558.9)
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems (601.9)	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon (564.1)
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia (783.0)	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS (042)
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder (790.6)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

**MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTONS.
INCLUDE SYMPTONS OF PAIN, NUMBNESS OR TINGLING**



