CROMWELL CHIROPRACTIC CENTER, LLC
Phone 860-635-4455 Fax 860-635-0499

CONFIDENTIAL PATIENT CASE HISTORY

How did you hear about this office? _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____

Email Address _____ Work Phone _____

Birthdate _____ Age _____ Sex M or F Marital Status M S W D # of children _____

Occupation _____ Employer _____

Emergency Contact _____ Phone # _____ Relation _____

HEALTH INFORMATION

Have you had previous chiropractic care? No Yes If yes, when? _____

What is your main complaint? _____

How long have you had this condition? _____

What activities aggravate your condition? _____

What is this current problem most preventing you from enjoying or performing? _____

_____

What activities improve your condition? _____

What does the pain feel like? (sharp pain, burning, numbing/tingling) _____

Does this radiate to other areas? No Yes If yes, where? _____

Rate your pain on a scale of 1 to 10 (1 = mild pain, 5 = moderate and 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What percentage of the day does this condition bother you? 25% 50% 75% 100%

Do you have another complaint? No Yes If yes, please describe below:

_____

How long have you had this condition? _____

What activities aggravate your condition? _____

What is this current problem most preventing you from enjoying or performing? _____

_____

What activities improve your condition? _____

What does the pain feel like? (sharp pain, burning, numbing/tingling) _____

Does this radiate to other areas? No Yes If yes, where? _____

Rate your pain on a scale of 1 to 10 (1 = mild pain, 5 = moderate and 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What percentage of the day does this condition bother you? 25% 50% 75% 100%

List other complaints: _____

_____

List other doctors who have treated the above conditions: _____

_____

List any tests that were performed and dates: (MRI's, X-Rays) _____

_____

List surgical operations and dates performed: _____

_____

List current medications: _____

_____

FAMILY PHYSICIAN NAME (PCP): _____ **PHONE #** _____

Address: _____ City _____

PERSONAL HEALTH HISTORY Please check all that apply

☐ Cancer	☐ Lack of motivation	☐ Cold hands/feet
☐ Heart Disease/Stroke	☐ Low pain threshold	☐ Teeth grinding
☐ Diabetes	☐ Difficulty walking	☐ Anxiety
☐ High Blood Pressure	☐ Low energy	☐ Restless sleep
☐ Rheumatoid Arthritis	☐ Constipation	☐ Feel sick often
☐ Under-aroused	☐ Easily distracted	☐ Heart Palpitations
☐ Depressed	☐ Over-aroused	☐ Racing mind

☐ Other

FAMILY HEALTH HISTORY Please check all that apply

☐ Cancer	☐ Stroke	☐ Rheumatoid Arthritis
☐ Heart disease	☐ Diabetes	☐ High Blood Pressure

☐ Other

INSURANCE INFORMATION

Is your condition due to an auto accident or job-related injury? Yes No
Do you currently have health insurance? Yes No
If yes, Name of Company _____ ID# _____

Are you covered by Medicare? No Yes If yes, ID# _____

Do you have secondary insurance? No Yes If yes, ID# _____

I understand that Cromwell Chiropractic Center, LLC will prepare any necessary reports and forms to assist me in making collections from my insurance company. I am requesting payment of government and health insurance benefits be made directly to Robert M. Shortell, D/B/A Cromwell Chiropractic Center, LLC who accepts assignment for services rendered. In addition, I authorize the release of any medical or other information necessary to process my claims. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Parent's Signature (if under 18) _____