Adirondack Family Chiropractic, P.C.

148 Margaret St, P.O. Box 3046
Plattsburgh, NY 12901
Phone (518)561-6004, Fax (518)561-0357

Dr. Carolyn F. Clauss Dr. Joseph J. Clauss

CONFIDENTIAL PATIENT CASE HISTORY

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS. PLEASE INDICATE "NA" (NOT APPLICABLE) WHEN A QUESTION DOES NOT APPLY TO YOU.

First Name: _____ Last Name: _____ Nick Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Soc. Security Number: _____ Gender: _____ Marital Status: M S D

Spouse's Name: _____ Spouse's Work Number: _____

Your DOB: _____ Occupation: _____

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

E-mail Address: _____ Emergency Contact Name: _____

Emergency Contact Number: _____ Your Employer: _____

Who Referred You? _____

Insurance information:

Do you have health insurance? Y N

Type of Insurance: ☐Cash ☐ Private ☐Workers Comp ☐No-Fault

Name of Company: _____ Policy #:_____

Group Name: _____ Group Plan #:_____

Are you covered by Medicare? Y N Are you Covered by Medicaid? Y N

Do you have a Secondary Insurance? Y N

Name of Company: _____ Policy #:_____

Group Name: _____ Group Plan #:_____

Health Information:

Have you ever been to a chiropractor before? Y N When? _____

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What is your Major Complaint? _____
_____

What activities aggravate your condition? _____

How long have you had this condition? _____ ever had this or a similar condition in the past? Y N

Other Complaints? _____

Is this condition progressively getting worse? ☐Yes ☐No ☐Constant Comes and Goes

Is this condition interfering with your? ☐Work ☐Sleep ☐ Sports ☐Other_____

How long has it been since you felt really good? _____

Have you seen other doctors for this problem? Y N Names: _____

List surgical operations if applicable: _____

Do you take any medications? Y N If so, Please List: _____

Have you been in an Accident? Y N ☐Auto ☐ Work ☐Home ☐Other_____

When? _____ Please Describe: _____

When was your last physical exam? _____ Performed by who? _____

What type of regular exercise do you perform? ☐None ☐Light ☐Moderate ☐Strenuous

What is your height and weight? Height __'____" Weight _____lbs

For each of the conditions listed below, place a check in the past column if you had the condition in the past. If you presently have a condition listed below, place a check in the present box.

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Mid Back Pain
☐	☐	Neck Pain	☐	☐	Low Back Pain
☐	☐	Upper Back Pain	☐	☐	Shoulder Pain
☐	☐	Elbow/Upper arm Pain	☐	☐	Wrist Pain

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Past	Present	
☐	☐	Hand Pain
☐	☐	Hip/ Upper leg Pain
☐	☐	Knee/ Lower leg Pain
☐	☐	Ankle/ Foot Pain
☐	☐	General Fatigue
☐	☐	Visual Disturbances
☐	☐	High Blood Pressure
☐	☐	Chest Pains
☐	☐	Angina
☐	☐	Kidney Disorders
☐	☐	Painful Urination
☐	☐	Prostate Problems
☐	☐	Loss of Appetite
☐	☐	Ulcer
☐	☐	Liver/ Gall Bladder
☐	☐	Tumor
☐	☐	Chronic Sinusitis
☐	☐	Excessive Thirst
☐	☐	Smoking/ Use of Tobacco Products
☐	☐	Depression
☐	☐	Epilepsy
☐	☐	HIV/ AIDS
☐	☐	Birth Control

Past	Present	
☐	☐	Jaw Pain
☐	☐	Joint Swelling/ Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Muscular In coordination
☐	☐	Dizziness
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Kidney Stones
☐	☐	Bladder Infection
☐	☐	Loss of Bladder Control
☐	☐	Abnormal Weight Gain/ Loss
☐	☐	Abdominal Pain
☐	☐	Hepatitis
☐	☐	Cancer
☐	☐	Asthma
☐	☐	Diabetes
☐	☐	Frequent Urination
☐	☐	Drug / Alcohol Dependence
☐	☐	Systemic Lupus
☐	☐	Dermatitis
☐	☐	Hormonal Replacement
☐	☐	Pregnancy

Allergies: _____

_____

Please read the below and sign:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I am ultimately the one responsible for seeing that my account is paid in full.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____