CONFIDENTIAL CASE HISTORY FILE

Aaron Keith, DC
17419 139th Ave NE Woodinville, WA 98072
425-485-8034 fax 425-368-2002

Full Legal Name: ____

Address: ____

City/State:____________________ Zip __________ Home Phone: _______________

Cell Phone:___________________ Work Phone: ______________________________

Male ( ) Female ( )

Birth Date: ___________________ Soc Sec # _______________________________

Spouse's Name (Parent's Name): ____________________ # Children: _____________

Emergency Contact: _______________________ Phone Number: _________________

Your Employer: ____

Employer's Address: ____

Job Title: ______________________ Email Address: ____________________________

How did you find us? ____

OUR OFFICE POLICY:

As a courtesy to our patients we are happy to verify your insurance benefits and bill your insurance carrier. However, this is not a guarantee of payment. At the time of receipt of our billing your insurance carrier will make a final determination of payment, if payment is denied it is then your responsibility to pay your charges in full. Copay is due at the time of each visit. If you have no insurance, all office visits must be paid for at the time of visit.

Please make any cancellations at least 24 hours prior to your appointment.

I authorize the staff to process insurance claims. I understand that I am responsible for payment of my account and that my insurance policy is a contract between me and my insurance.

SIGNATURE: _____________________________________ DATE:_______________

MEDICAL HISTORY (Please answer all questions)

List any surgeries (include dates and reason):

____

List any hospitalizations (include dates and reason):

____

List auto accident injuries (include dates):

____

List any on the job injuries (include dates):______________________________

List any current or past major medical conditions you have had (cancer, diabetes, arthritis, back problems, etc.):

____

List all current over-the-counter and prescription medications and reason:

____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)______________________________

Have you been under a physician's care in the past year? ☐ no ☐ yes

Reason?______________________________

When was your last physical exam? ______________________________

Primary Care Doctor? ______________________________

Have you ever been under chiropractic care? ☐ no ☐ yes **Describe:** ______________________________

If female, is it possible you are pregnant? ☐ no ☐ yes **Do you smoke/use tobacco?** ☐ no ☐ yes

Exercise habits? ☐ never ☐ occasional ☐ frequent

____

Check any of the following symptoms you have noticed:

Prev/Now

☐ ☐ Headaches
☐ ☐ Dizziness or Lightheaded
☐ ☐ Jaw Pain, clicking, or locking
☐ ☐ Pain or difficulty swallowing
☐ ☐ Neck pain or stiffness
☐ ☐ Shoulder pain
☐ ☐ Mid back pain
☐ ☐ Chest pain or cough
☐ ☐ Pain/trouble breathing
☐ ☐ Arm/hand numbness/tingling
☐ ☐ Arm/hand fatigue/weakness

☐ ☐ Low back pain
☐ ☐ Leg/foot numbness/tingling
☐ ☐ Leg/foot fatigue/weakness
☐ ☐ Leg pain with walking
☐ ☐ Abdominal pain
☐ ☐ Nausea or vomiting
☐ ☐ Diarrhea or constipation
☐ ☐ Blood in urine or stool
☐ ☐ Difficulty or pain w/urination
☐ ☐ Difficulty with sexual function
☐ ☐ Abnormal menstrual periods

☐ ☐ Sensitive to light or sound
☐ ☐ Visual/hearing disturbance
☐ ☐ Memory loss/problems
☐ ☐ Irritability or depression
☐ ☐ Fatigue or loss of energy
☐ ☐ Fainting or convulsions
☐ ☐ Trouble with balance/ coordination
☐ ☐ Sleep disturbances/problems
☐ ☐ Rashes (face, body, limbs)
☐ ☐ Joint pain or swelling
☐ ☐ Pain with exertion (activity, climbing stairs, etc.

____

HAVE YOU HAD *ANY* OF THE FOLLOWING NOW:

☐ Pain worse at night
☐ Constant pain
☐ Unexplained weight loss
☐ Recent bacterial infection (30 days)
☐ Loss of bowel or bladder control
☐ Urinary discharge
☐ Recent surgery (30 days)

EVER:

☐ History of cancer
☐ History of IV drug use
☐ History of blood transfusion

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Information about your current condition/complaints:

What is your primary complaint/problem? ______________________
List other symptoms: ______________________
When did your symptoms first begin (date if possible)? ______________________
How did you symptoms first begin? ______________________

Pain is: ☐ Constant ☐ Intermittent Is your condition getting worse? ______
What activities aggravate your condition? ______________________
____

List all doctors/therapists/specialists seen for this problem and treatment given:
1. ______________________
2. ______________________
3. ______________________

Have you had: Xray ☐ MRI or CT scan ☐ EMG ☐ Bone Scan ☐ Blood Work ☐
Who is your family Medical Doctor? ______________________
List all home remedies tried for this problem: ______________________
Is your condition worse at certain times of the day or night? ______________________
Does your condition interfere with: Work _____ Sleep _____ Normal daily routine ____

Have you had symptoms like this before? ☐ Yes ☐ No

Describe______________________

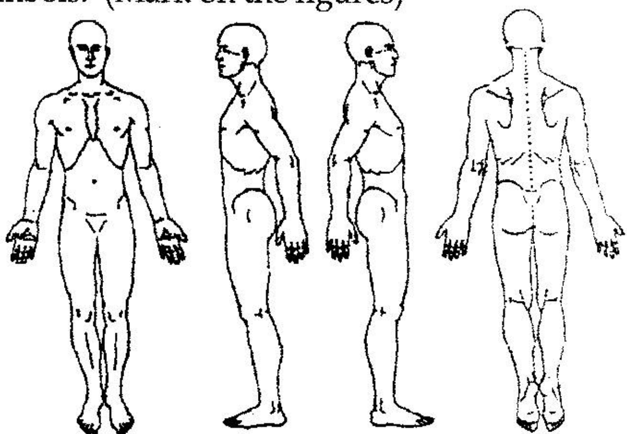
Regarding your main complaint:
How bad is your pain? Make a slash on each line.

1. **Right now:** 1______________________10
2. **Average:** 1______________________10
3. **At worst:** 1______________________10

0= no pain 10= worst pain imaginable

Draw the area of your symptoms using these symbols: (Mark on the figures)

XXX= ache
* = sharp/stab
ooo = numb/tingle
→ = shooting
/// = stiff/tight



NOTICE: I grant permission to Dr. Keith to use the information in my medical record to assist in the clinical improvement process.

Patient Signature: ______________________ Date __________