MOUNTAINSIDE WELLNESS CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION DATE: _____

Name: _____ SS# _____ Home Phone: _____

EMAIL Address: _____ Cell Phone: _____ Emergency#_____

Address: _____ City: _____ State: _____Zip Code: _____

Age: _____ Date of Birth: _____ Marital Status: M S D W How Many Children? _____

Occupation: _____ Employer: _____

Employers Address: _____ Office Phone: _____

Name of Spouse: _____ Occupation: _____

Spouses Employer: _____ Address: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

Who may we thank for referring you? _____
Is condition due to an accident? Yes___No___ Date_____ Type of Accident Auto___Work___Home___Other____
To whom have you made a report of your accident? Auto Ins___Employer___Workers Comp___Other____

Date of your last physical examination: _____ Who is your Primary Physician? _____
Primary Physicians Address and Phone Number: _____
Would you like a report on your condition to be sent to your Primary Physician? _____
What operations have you had? _____ When: _____
Have you ever had a serious illness? _____ When: _____
Have you ever suffered from any of the following? Check all that apply:

_____Dizziness	_____Arthritis	_____Digestive Disorder	_____Diabetes	____AID/HIV
_____Back Pain	_____Headache	_____Nervousness	_____Asthma	____Alcoholism
_____Heart Trouble	_____Numbness	_____Sinus Trouble	_____Cancer	____KidneyDisease
_____Depression	_____Liver Disease	_____Breast Lump	_____WeightChange	____Stroke
_____Hernia	_____Fractures	_____HerniatedDisc	_____Osteoporosis	____PinchedNerve

Other? Please describe: _____

Reason for Visit? _____
Have you seen any other doctors for this condition? _____ Yes _____ No Who? _____
Type: _____Chiropractor _____MD _____Medications _____Surgery _____Other _____
Has a physician treated you in the last year for any other health reason? _____Yes _____ No
If yes please describe: _____
Please list any medications or drugs you are currently taking? _____

Insurance Company_____Secondary Insurance_____

Assignment and Release

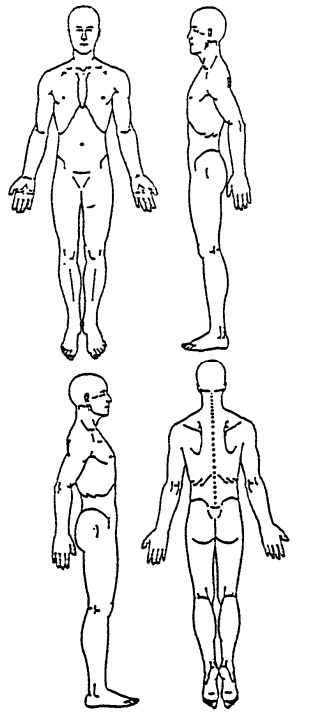
I certify that I, and/or my dependent(s), have insurance coverage with the carrier listed above and assign directly to Dr. Stephen M. Totin and Mountainside Wellness, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I authorize the use of my signature on all insurance submissions. The above name doctor/institution 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 and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

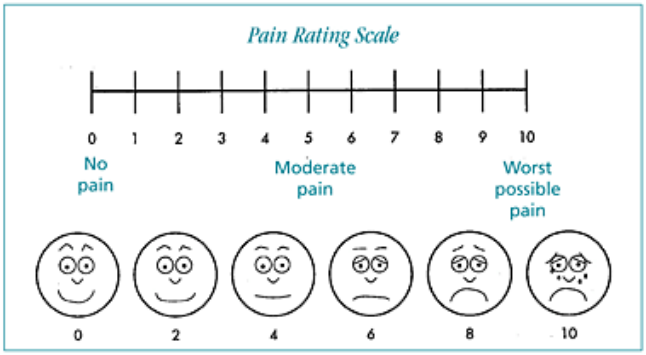
Patients Signature: _____ Date: _____
Guardians Signature Authorizing Care: _____ Date: _____

-OVER-

1. Describe your major complaint and how the problem began: _____
   _____
   Secondary Symptom: _____
   Other Symptoms: _____
2. When did your symptoms originally appear? _____
   How did it occur? _____
   Has it become worse recently? Yes _____No _____Same _____Better _____
3. How frequent is the condition? Constant(81-100%)___Frequent(51-80%)__Occasional(26-50%)___ Intermediate(25% or less)____
   How long does it last? All Day _____Few Hours _____Few Minutes____
   Is your problem affecting your ability to do work or do other routine activities?_____
   No Effect ___Have some restriction but can function ___Need assistance ___Can work ___Totally disabled___
4. Describe the pain: ___ Sharp ____Dull ___ Numbness ___ Tingling ___ Aching ____Burning _____Stabbing
   Other: _____
5. Is there anything you can do to relieve the problem? Nothing_____Walking _____Standing _____Sitting_____
   Moving Around or Exercise _____Lying Down_____ Anti-inflammatory Medication_____
6. What makes the problem worse? _____Standing _____Sitting _____Lying _____Bending _____Lifting
   Other: _____
7. Any Injuries/Surgeries? _____ Yes _____ No If yes, please list and give dates: _____
   _____
8. What is your physical activity at work? _____Mostly Sitting _____Light Manual Labor _____Moderate Manual Labor _____Heavy Manual Labor
9. Do you exercise?Yes___ No___What type of sports? _____
   1-2 times week _____3-4 times week _____5-7 times week___Cardiovascular_____Weight Training____
10. What is your present level of stress? _____None _____Minimal _____Moderate _____Severe
11. Women Only: Are you pregnant or is there any possibility you may be pregnant? ____ Yes _____No _____Uncertain
12. Do you smoke? Yes _____No____Number per day? _____
13. How much alcohol do you drink on a weekly basis?_____How many caffeine beverages do you drink per day?_ ___

Please Mark an X on the picture where you have pain, numbness or tingling and circle the pain scale.





Doctors Signature: _____ Date: _____