Welcome to the Baum Chiropractic Clinic

Our mission is to help people obtain optimal health using natural chiropractic care, massage and physical therapy and acupuncture.

Confidential Case History

PID - Personal Identification Number

____ ____ First 2 initials of last name

____ ____ ____ ____ Last 4 digits of Social Security Number or # you will remember

Last Name, First ______________________ **SS#:** ______________ ☐ **Male** ☐ **Female**

Address ______________________ **Marital Status** ______ **# of Children** ____

(City/State/Zip) ______________________ **Age** ________ **DOB** ___/___/____

Home Phone ______________________ **Cell Ph.:** ______________ **Work Phone** ____________

Occupation ______________________ **Spouse Name:** ______________ **E-Mail Address:** ____________

Emergency Name ______________________ **Phone #:** ______________

How did you find out about our office? ☐ **Friend** ____________ ☐ **Insurance Book** ☐ **Yellow Pages** ☐ **Internet** ☐ **Walk In/other**

Which doctor were you referred to? __ Dr. Michael N. Baum __ Dr. Cindy Pekofsky __ Dr. Jennifer D. Marder

PLEASE CIRCLE, CHECK OFF OR FILL IN THE BLANK THAT APPLIES TO YOU.

1) Where is your major complaint? ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Lower Back ☐ Shoulder ☐ Knee ☐ Wrist ☐ Other____

2) Does the pain radiate to another area? Yes___ No___ Where? __________

3) How often do you feel this pain? ☐ Constantly ☐ Frequently ☐ Occasionally

4) The pain is: ☐ Sharp ☐ Achy ☐ Throbbing ☐ Tingling ☐ Burning ☐ Numbing

4a) Level of Pain – ***Please circle*** 1 2 3 4 5 6 7 8 9 10

No Pain......................Moderate Pain..................... Extreme Pain

5) The pain is worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Constant

6) Does this complaint interfere with your: ☐ Sleep? ☐ Personal activities? ☐ Work?

7) Any other complaints you have: ☐ No ☐ Yes ______________________

Please Explain

8) List all doctor's who have treated you for this complaint:

☐ None ☐ MD/DO ☐ DC ☐ PT

☐ other ____________________

9) What type of treatment did you receive?

☐ Rx ☐ Therapy ☐ X-rays, MRI ☐ Adjustment

Response to treatment: Bad ....Medium........Excellent

10) Check off all conditions that apply to you:

☐ Headaches	☐ Heart problems	☐ Diabetes
☐ Nervousness	☐ Diarrhea	☐ High Blood Pressure
☐ Depression	☐ Constipation	☐ Decreased Energy
☐ Stroke	☐ Weight Loss	☐ Hypoglycemia
☐ Ringing in ears	☐ Visual problems	☐ Asthma
☐ Loss of memory	☐ Allergies	☐ Cancer
☐ Urination Problems	☐ Other ____________________ Please Explain	

11) Past History*

☐ HIV ☐ Hepatitis ☐ TB ☐ Accidents

☐ Surgery Explanation: ____________________

***HIPAA Compliant**

☐ Accidents ☐ Injuries Please Explain: ____________________

☐ Treatment ☐ Active Care ☐ Non-Active Care

12) Social History

☐ Drinking ____________ Frequency ☐ Smoking ____________ Frequency

13) Family History

(Mother, Father, Grandparents, Brothers & Sisters)

☐ Diabetes	☐ Cancer	☐ Thyroid Disease
☐ Blood Pressure	☐ Kidney Disease	☐ Scoliosis
☐ Heart Disease	☐ Stroke	☐ Other __________

14) Name of Primary Physician ____________________

Date of last Physical Exam, EKG, X-rays, Blood tests: ____________________

15) Medication History

☐ __________ For what condition: ____________________

☐ __________ For what condition: ____________________

☐ Birth Control For what condition: ____________________

16) Name of Past Chiropractor ______________

Date of last adjustment ______________

What complaints did you go for? ______________

17) Have you had an auto accident or work related injury ☐No ☐Yes ______________
Please Explain

18) Exercise History

__________Days per Week

__________Duration/Time Exercise

List types of Exercise: ______________

Goal: ______________

19) Vitamin/Mineral History

☐Vitamins ______________
Name & Frequency

☐ Minerals ______________
Name & Frequency

20) Diet History

☐Breakfast Describe w/portions

☐Lunch Describe w/portions

☐Dinner Describe w/portions

☐Snacks Beverages:

Goal: ______________

21) Parent's History

	Body type	Exercise	Diet
Mother	______	______	______
Father	______	______	______
	(Thin, Medium, Fat)	(None, light, Regular)	(Poor, OK, Excellent)

Additional Explanation/Comments: ______________

____

I am interested in ☐Chiropractic ☐Physical Therapy ☐Massage ☐Acupuncture ☐Nutrition ☐All

Thank you for taking the time to fill this form out!