PATIENT CASE HISTORY

Rafey Chiropractic and Health Center
Achieving Your Health Success
Dr. Jennifer Rafey

Today's Date: _____

Name: (Last, First MI) _____ Preferred Name: _____

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

Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____

Email: _____ Gender: M / F Marital Status: Married / Other / Single

Social Security #: _____ Date of Birth: _____

Student Status: Full Student / Part Student / Non-Student ☐ Employed Employer: _____

*Referred By: _____ Preferred Language: _____

Smoking Status: Every Day / Some Days / Former / Never

Full Name: _____ Primary Care Physician: _____

Home: _____ Mobile: _____ Doctor's Phone: _____

Relationship: Child / Parent / Spouse / Other: _____

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain): _____

PRIMARY INSURANCE / PERSONAL AUTO

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

SECONDARY INSURANCE / AT FAULT AUTO INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

AUTOMOBILE / WORK RELATED INJURY

Do you have an attorney: Yes / No

Attorney Name: _____ Phone # _____

Agent Name: _____ Agent Number: _____

Who is responsible for payment? Self / Other - *(Relationship)* _____

Other than Self:

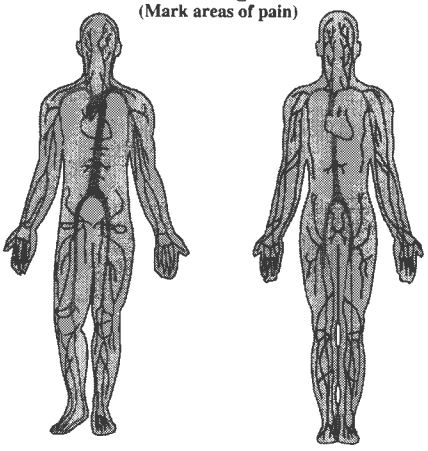
Full Name: _____ Phone: _____

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

Employer: _____

It is usual and customary to pay for services as rendered unless otherwise arranged.

Pain Diagram
(Mark areas of pain)



Front Back

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Neck-Shoulder-Arm-Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 10

no pain severe pain

Mid Back Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 10

no pain severe pain

Low Back and Leg Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 10

no pain severe pain

Describe Major Complaint: _____

Began When? ____/____/____ **Describe how this began:** _____

_____

_____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? *(Describe)* _____

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____
- **Had any previous Surgery or Interventions in this area?** *(Describe)* _____
- **Taken any Medications?** OTC / Prescriptions _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

Describe any Secondary Complaints: _____

Medications:

Allergies to Medications: *NONE (List)* _____

_____

Current Medications: *NONE*

(Already have a list? We can make a copy.) _____

_____

_____

_____

_____

Past Health History: *(Please list any past...)*

Surgeries - Date, Type, and Reason: *NONE*

_____

_____

_____

_____

Major Injuries/Traumas: *NONE* _____

_____

_____

_____

Major Hospitalizations: *NONE* _____

_____

_____

Family Health History: *(Please mark N/A if not relevant.)*

List *relevant* major health problems of immediate relatives:

_____

_____

_____

Deaths in immediate family: *(Cause and at what Age?)*

_____

_____

_____

Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

_____

_____

_____

_____

Habits:

Cigarettes - *(#/day)* _____

Alcohol - *(amount/day)* _____

Coffee/Tea - *(cups/day)* _____

Rec. Drugs *(List)* _____