WELCOME

Northeastern Spinal Health & Rehabilitation (973) 812-0202

CONFIDENTIAL CASE HISTORY

PATIENT INFORMATION

Today's Date: _____ Referred by: _____

Patient's Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Sex: [ ] M [ ] F Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Marital Status: M S D W Children: How many? _____ Occupation: _____

Employer: _____ Phone: _____ Ext: ____

Employer's Address: _____

SPOUSE/PARTNER'S INFORMATION

Spouse/Partner's Name: _____ Date of Birth: _____

Occupation: _____

Employer: _____ Phone: _____

IN CASE OF EMERGENCY, CONTACT INFORMATION

Name: _____ Relationship to you: _____

Home Phone: _____ Work Phone: _____ Alternate Phone: _____

INSURANCE INFORMATION

Name of insurance company? _____

Who is the subscriber for this account? _____

Subscriber's Date of Birth: _____ Subscriber's Social Security #: _____

Patient's relationship to the insured? [ ] Self [ ] Spouse [ ] Child [ ] Other _____

Is the patient covered by additional insurance? [ ] Yes [ ] No

Who is the subscriber for this account? _____

Subscriber's Date of Birth: _____ Subscriber's Social Security #: _____

Patient's relationship to the insured? [ ] Self [ ] Spouse [ ] Child [ ] Other _____

WHAT BRINGS YOU INTO OUR OFFICE?

Describe IN DETAIL the reason for your appointment? _____

Is this condition due to: [ ] Personal Injury [ ] Auto Accident [ ] Work Injury [ ] Other: _____

How long has it been bothering you? _____ Has it bothered you before? [ ] Yes [ ] No How long ago? _____

Is this condition: [ ] getting worse [ ] constant [ ] comes & goes

Does this condition interfere with: [ ] Work [ ] Sleep [ ] Daily Activities [ ] Other: _____

What activities aggravate this condition? _____

What activities alleviate this condition? _____

Have you done anything to treat this condition yourself? [ ] Yes [ ] No If yes, explain: _____

Have you seen any other doctors for this condition? [ ] Yes [ ] No If yes, give names & diagnosis by each: _____

_____

PAST MEDICAL HISTORY

Name of Primary Physician: _____ Address: _____

In order for the doctor to make an accurate assessment of your condition, the following information is required, regardless of whether or not it is related to your present condition.

Have you been treated by a physician for any condition in the past year? [ ] Yes [ ] No If yes, describe: _____

_____

_____

Have you ever been hospitalized? [ ] Yes [ ] No If yes, list reason and dates: _____

_____

_____

Have you ever fractured or broken any bones? [ ] Yes [ ] No If yes, describe and give dates: _____

_____

_____

Have you ever been involved in any auto accident? [ ] Yes [ ] No If yes, describe and give dates: _____

_____

_____

Have you ever had any other serious injuries? [ ] Yes [ ] No If yes, describe and give dates: _____

_____

_____

Please list any prescription or non-prescription medications and/or vitamins that you are currently taking: _____

_____

_____

Have you ever been under chiropractic care? [ ] Yes [ ] No Date of last adjustment: _____

Doctor's Name: _____ City & State: _____

PLEASE CHECK ALL CONDITIONS THAT YOU PRESENTLY HAVE OR HAVE HAD IN THE PAST

[ ] Headaches	[ ] Asthma	[ ] Allergies	[ ] Digestive Disorder
[ ] Migraines	[ ] Diabetes	[ ] Hay Fever	[ ] Heart Problems
[ ] Neck pain	[ ] Tuberculosis	[ ] Sinus Troubles	[ ] AIDS
[ ] Numbness in arms & hands	[ ] Arthritis	[ ] Colds	[ ] HIV Virus
[ ] Back pain	[ ] Anemia	[ ] Dizziness	[ ] Rheumatic Fever
[ ] Sciatica	[ ] High Blood Pressure	[ ] Nervousness	[ ] Excessive Menstrual Flow
[ ] Numbness in legs & feet	[ ] Low Blood Pressure	[ ] Bruises Easily	[ ] Irregular Menstrual Cycle
[ ] Spinal Curvature	[ ] Cancer	[ ] Stroke	[ ] Other: _____

SOCIAL HISTORY

HEALTH HABITS: Check (√) which substances you use and describe how much you use.

[ ] Caffeine _____ [ ] Alcohol _____ [ ] Drugs _____ [ ] Tobacco _____ [ ] Other _____

OCCUPATIONAL HABITS: Check (√) if your work exposes you to the following.

[ ] Stress [ ] Heavy Lifting [ ] Hazardous Substances [ ] Other _____

SIGNATURES

I do hereby certify that all of my statements on this application for chiropractic care are true, accurate, and complete. I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out instructions.

Patient's Signature: _____ Date: _____

FOR WOMEN ONLY

By my signature below, I do hereby state that, to my best knowledge, I am neither suspected nor confirmed pregnant at this time.

Patient's Signature: _____ Date: _____

CONSENT TO TREAT A MINOR CHILD

I do hereby give my permission to Dr. Michael Czupak, D.C. and Dr. Emily Stoppiello-Czupak, D.C. to treat my child.

Minor Child's Name: _____

Signature of Parent or Legal Guardian: _____ Date: _____