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. Gordon J. Braun**

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 _____ ☐ Smoking _____
Frequency Frequency

13) Family History ☐Diabetes ☐Cancer ☐Thyroid Disease

(Mother, Father, Grandparents, Brothers & Sisters) ☐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

Mother	**Body type** _____	**Exercise** _____	**Diet** _____
Father	**Body type** _____	**Exercise** _____	**Diet** _____
	(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!