Phoenician Health Group
Case History/Patient Information

Doctor _____ _____

❒ 3244 E. Indian School Rd Phoenix 85018
❒ 4845 E. Thunderbird Rd. Suite 4 Scottsdale 85254

Please PRINT clearly

General Information

Name: _____Date: _____
Address: _____City: _____State:_____Zip Code: _____
Home Phone: _____Work Phone: _____E-mail_____
Social Security # _____Date of Birth: _____Age: _____ Sex: ❒ Female ❒ Male
Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed Do you have any children? ❒yes ❒no how many?_____
Employer _____Occupation_____
How did you hear about us?_____
Primary Care Physician Name and Phone_____
Have you ever had Chiropractic care before? ❒yes ❒no If yes, when was your last treatment?_____
May we contact your medical doctor to inform them of your exam results and treatment plan? ❒ yes ❒ no

Complaint History

1. Describe your current complaint and how the problem began: ❒auto accident ❒ other accident ❒work related
explain:_____❒gradual ❒sudden ❒no specific reason

_____

_____

2. How long have you had this problem?_____
3. Have you ever had this problem or a similar problem before? ❒ yes ❒ no When?_____
4. How would you describe your present complaint/pain?
❒ sharp ❒ soreness ❒ throbbing ❒tingling ❒dull ❒ stiffness
❒ spasm ❒ burning ❒ ache ❒ weakness ❒ numbness ❒ shooting

5. How often is the pain present?
❒constant (81-100%) ❒ frequent (51-80%) ❒ occasional (26-50%) ❒ intermittent (25% or less)

6. Since your problem began, is the pain: ❒ getting worse ❒ getting better ❒ Staying the same
7. What makes your problem better?
❒ nothing ❒ walking ❒ standing ❒ sitting ❒ activity/exercise ❒ lying down ❒ inactivity
8. What makes your problem worse?
❒ nothing ❒ walking ❒ standing ❒ sitting ❒ activity/exercise ❒ lying down ❒ inactivity

9. How would you rate the intensity of your pain? (circle the appropriate number)
0 1 2 3 4 5 6 7 8 9 10
(no pain) (moderate pain) (unbearable pain)

10. How would you rate your commitment to your health? (circle the appropriate number)
0 1 2 3 4 5 6 7 8 9 10
(low) (moderate) (high)

11. Are you currently taking any medications, herbs, vitamins, and/or nutritional supplements?
❒ yes ❒ no *if yes, please describe:*_____
Are you interested in personalized nutritional recommendations? ❒ yes ❒ no

12. Have you ever been treated for this same problem? ❒ yes ❒ no If yes, by whom? ❒ MD ❒ Chiropractic
What were the approximate dates, type of treatment and the results?_____
_____

13. What is your level of physical activity/exercise ?
❒Heavy (5-7 days/wk) ❒ Moderate (3-4 days/wk) ❒Light (1-2 days/wk) ❒None
❒ cardiovascular ❒ stretching ❒ strength training ❒ sports _____

13. How are your eating habits? ❒ Professionally recommended diet ❒ Good ❒ Fair ❒ Poor
Are you interested in having a nutritional analysis/consultation? ❒ yes ❒ no

14. What is your present general stress level: ❒ High ❒ Moderate ❒ Minimal ❒ None

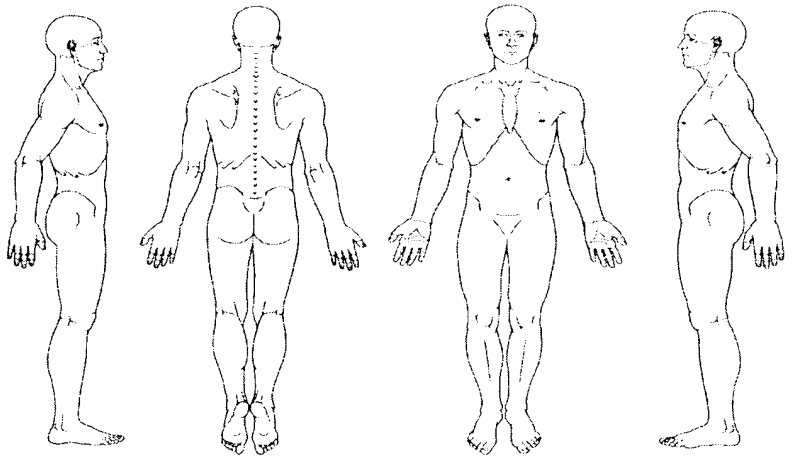
Past or Present Symptoms/Conditions

Below is a list of symptoms and conditions. Please check the box indicating whether this applies to the past or present.

	past	present		past	present	
Neck pain……	❒	❒	High blood pressure……	❒	❒	Tobacco use:
Shoulder pain……	❒	❒	Heart condition……	❒	❒	❒ past ❒ present
Arm/elbow pain……..	❒	❒	Respiratory condition…..	❒	❒	❒ occasional
Hand pain……	❒	❒	Digestive problem……	❒	❒	❒ moderate ❒ heavy
Upper back pain……	❒	❒	Menstrual problem……	❒	❒	
Lower back pain……	❒	❒	Sinus problem……...	❒	❒	Alcohol use:
Hip/thigh pain……..	❒	❒	Asthma……	❒	❒	❒ past ❒ present
Knee/leg pain……..	❒	❒	Skin condition……	❒	❒	❒ occasional
Ankle/foot pain……	❒	❒	Diabetes……..	❒	❒	❒ moderate ❒ heavy
Jaw pain……..	❒	❒	Cancer……	❒	❒	
Headaches……..	❒	❒	Allergies_____			Caffeine use:
Dizziness……	❒	❒	Surgeries_____			❒ past ❒ present
						❒ occasional
						❒ moderate ❒ heavy

Family History_____

Using the figures below, please shade in the areas where you have pain or any other symptoms.



Consent for Treatment

I hereby authorize the treating physician and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to be paid directly to the treating physician for services rendered.

Patient's Signature

_____**Date**_____

Guaridan's Signature (if minor)

_____**Date**_____