Priestley *Chiropractic*

Dr. Walter F. Priestley, DC DICCP *Dr. Christopher Wider, DC*

CONFIDENTIAL PATIENT CASE HISTORY

Name____ Social Security__________________________________

Address______________________________________City___________________________State_______ Zip ____________

Age_______ Date of Birth __________Marital Status ______ No. Of Children_______ Referred By __________________

Occupation______________________________________ Employer____

Emergency Contact and Phone Number ____

Good communication between doctors and patients are essential. We often need to do follow up calls and e-mails for patients in pain. Please provide us with your e-mail address and best phone numbers to reach you. You will be provided with our personal e-mails and cell phone numbers.

E-Mail____ Cell Phone____________________________________

Home Phone ____ Work Phone___________________________________

Please CIRCLE which is the preferred method of contact. E-mail, Work, or Home Phone.

HEALTH INFORMATION:

What is your major complaint? ____

Other Complaints ____

Onset of condition ____

Other doctors who treated this condition ____

Is this injury related to work or auto injury? ____________________________ Date of Injury _________________________

INSURANCE INFORMATION

Primary Insurance

____

I hereby authorize assignment of my insurance benefits directly to Dr. Priestley for services rendered in this office. I authorize Dr. Priestley's office to obtain necessary medical records and release medical records to other healthcare providers or third party.

Signature ____ Date_________________________

Patient Health Questionnaire - page 2

Managed Physical Network

MPN Use Only rev 5/7/99

Patient Name ______________________ **Date** ______________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height ___ ___ (Feet, Inches) Weight ___ ___ ___ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	Condition
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	Condition
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

Past	Present	Condition
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

Past	Present	Condition
○	○	
○	○	
○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ ______________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature ______________________ **Date** ______________

Provider's Additional Comments

Doctors Signature ______________________ **Date** ______________

PRIVACY NOTICE

Essentially our privacy policy states that we do not give out your medical information to anyone other than your insurance company, yourself, or another doctor involved in your care. IF you would like to see the complete detailed policy, you may request a copy at the front desk. If you would like us to release your medical information to someone other than above, we need to be notified verbally or in writing.

If you request any specific restrictions regarding your privacy, please discuss it with the doctor.

By signing below, you acknowledged that you have read and understand the above.

Signature ____

Date ____