Boyd Chiropractic Clinic
3271 West 26th Street
Erie, PA 16506

Phone: (814) 836-0440
Fax: (814) 835-0256

CONFIDENTIAL PATIENT CASE HISTORY

First Name__________________M.I_____Last Name__________________ Date____/___/____

Address:____

City:______________________________State:________________________Zip:_____________

Home Phone #__________________Cell #____________________Work #_________________

Email Address:____

Birth Date:_____/______/_____Age:_________Social Security Number:_______-_____-_______

Employer's Name:______________________________Occupation:________________________

Marital Status: S M D W Spouses Name:_______________________Number of Children____

In Case of an emergency, notify:_______________________At phone #____________________

Whom may we thank for referring you to our office?____________________________________

Insurance Information

Insured's Name ____

Insured's Employer ____

Insured's S.S. Number_________-________-________ Insured's DOB______/_____/________

Relationship to Patient___________________ Name of Insurance Carrier__________________

Health Information

Have you had previous chiropractic care? Y N Where?_______________When?____________

Primary complaint (Why are you here today?):____

How long have you had this condition?____________Have you had this problem in the past?Y N

What activities are you unable to do now, that you were able to do prior to this condition?_______

____

Is this condition interfering with: ( )Work ( )Sleep ( )Daily Routine ( )Other_________

What makes it better?____

How long since you've felt really good?____

Primary Care Physician (PCP):____

Other health complaints:____

Females: Is there any chance that you are pregnant? ( )Yes ( )No

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Medications/Vitamins/Supplements you currently take:_______________________________

Surgical operations and years:____

Date of your last physical exam:______/______/_______

Is your condition due to an auto accident or job related injury? ( )Yes ( )No

Have you been in any auto accidents in: ( )past 2 yrs ( )2 - 5 yrs ( )5+ yrs ( )never

If yes, please describe the auto accident(s):_______________________________________

____

Have you had any other personal injury accidents? ( )past 2 yrs ( )2 - 5 yrs ( )5+ yrs ( )never

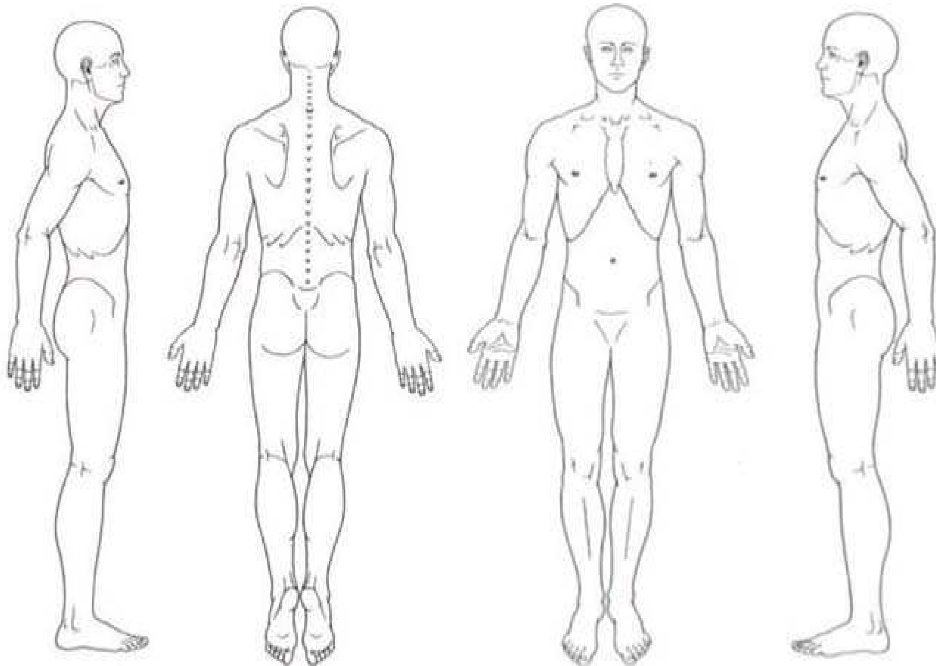
If yes, please describe the accident(s):____

____

MARK THE AREAS ON YOUR BODY WHERE YOU HAVE SYMPTOMS

USE THE SYMBOLS BELOW

• NUMBNESS ○ PINS & NEEDLES × BURNING ~ STABBING



CIRCLE A NUMBER TO INDICATE YOUR PAIN LEVEL:

When the problem began:	**Right now:**
Gone 0 1 2 3 4 5 6 7 8 9 10 Unbearable	**Gone 0 1 2 3 4 5 6 7 8 9 10 Unbearable**

Patient Signature: ______________________________________ **Date:** ________________