Dr. Eva Turner 10 East 704th St, Orangeburg NY 10962 845-359-5599

CONFIDENTIAL PATIENT CASE HISTORY

Patient Information:

Name_____SS#_____Birth Date_____

Address_____City_____State_____ZIP_____

Home Phone_____Work Phone_____Cell Phone_____email_____

Age_____ Sex____ Check One: ___Married__ Single__ Widowed__ Divorced__ Separated No. Of Children_____

Business/Employer_____Occupation_____

Spouse Information:

Name _____ Birth Date_____SS#_____

Employer_____ Occupation_____Work Phone_____

Emergency Contact Information:

Name_____Relationship_____Phone _____

Policyholder - Insurance Information:

Name_____Birth Date_____Relationship to patient_____

SS#_____Insurance ID #_____Group#_____

Insurance Company Name_____Address_____

Phone #_____Type of Insurance:__Worker's Comp__ Auto __Medicare __Medicaid

CURRENT HEALTH CONDITION

Purpose of Appointment_____

When did this condition begin?_____How long have you had this condition?_____Has it occurred before?_____

How many times?____What makes condition worse?_____Other Doctors Seen for this condition_____

Treatments Received_____Results_____

Drugs you now take_____

PAST HEALTH HISTORY

Please check and describe any Major Surgery/Operations: __Appendectomy__Tonsillectomy__Gall Bladder__Hernia

__Back Surgery__Broken Bones__Other_____

Major Accidents or Falls_____

Other Hospitalizations_____

Previous Chiropractic Care__None __Doctor's Name and Date of last Visit_____

Dr. Eva Turner 10 East 704th St. Orangeburg NY 10962 845-359-5599

PLEASE CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:

__Pneumonia
__Rheumatic Fever
__Polio
__Tuberculosis
__Whooping Cough
__Anemia
__Measles
__Mumps
__Small Pox
__Chicken Pox
__Diabetes
__Cancer
__Heard Disease
__Thyroid
__Influenza
__Pleurisy
__Arthritis
__Epilepsy
__Mental disorders
__Addictions
__Eczema

INTAKE
__Coffee
__Tea
__Alcohol
__Cigarettes
__White Sugar

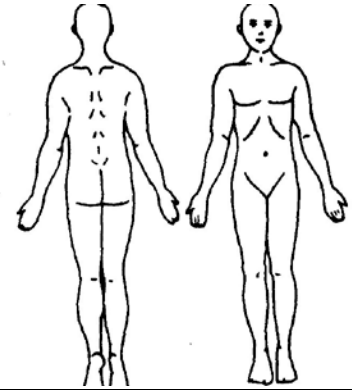
CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL
__Low Back Pain
__Pain Between Shoulder
__Neck Pain
__Arm Pain
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing/Clicking Jaw
__General Stiffness

NEUROLOGICAL SYSTEM
__Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion/Depression
__Fainting
__Convulsions
__Cold/Tingling Extremities
__Stress

GENERAL
__Fatigue
__Allergies
__Loss of Sleep
__Fever
__Headaches

FEMALES ONLY
Last Period Date_____
Are you pregnant?
__Yes __No __Not Sure



OUTLINE YOUR AREA OF PAIN

GENITO-URINARY
__Bladder Trouble
__Painful Urination
__Excessive Urination
__Discolored Urine

CARDIO-VASCULAR
__Chest Pain
__Shortness of Breath
__Blood Pressure Problems
__Irregular Heartbeat
__Heart Problems
__Lung Problems
__Congestion
__Varicose Veins
__Ankle Swelling
__Stroke

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Aches
__Hearing Difficulty
__Stuffed Nose

FEMALE/MALE
__Menstrual Irregularity
__Menstrual Cramps
__Vaginal Pain
__Vaginal Infection
__Breast Pain/Lumps
__Prostate Problems
__Sexual Dysfunction

FAMILY HISTORY MEMBER
__High Blood Pressure_____
__Thyroid Problems_____
__Diabetes_____
__Stroke_____
__Heart Disease_____
__Cancer_____
__Tumors_____
__Other Illness_____
_____
_____

GASTRO-INTESTINAL SYSTEM
__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Liver Problems
__Gall Bladder Problems
__Weight Trouble
__Abdominal Cramps
__Heartburn Gas/Bloating after Meals
__Black/Bloody Stool
__Colitis

DOCTOR'S NOTES: