COMEAU HEALTH CARE ASSOCIATES, PC

Wayne A. Comeau, DC, DACBOH
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194 NORTH STREET
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Patient Case History

A thorough case history is an important part of evaluating your condition and arriving at a diagnosis. Please fill out this form in as much detail as possible. The doctor will review the history with you and answer any questions you might have.

Please note that some questions on this form are required by Medicare.

Personal Data

Today's Date:_______________

Patient Title: ___Mr ___Mrs ___Ms ___Miss ___Dr ___Prof ___Rev

First Name:_________________________________ Middle Initial:________

Last Name:_________________________________ Suffix_____

Nickname:_______________________________ Gender: ___Male ___Female ___Unspecified

Marital Status: ___Married ___Single ___Widowed ___Other

Date of Birth:________________________ Age:_________ Social Security #____-____-______

Address:_________________________ _____City:__________________ State:_____ Zip:__________

Home Phone: _________________Cell Phone: ________________ Work Phone:_________________

Best Number to confirm appointments? ___Home ___Cell ___Work

E-Mail address: ____

Verification question: (**Choose only one question by circling the question, then give the answer to that question.)**
___What is the name of your favorite pet? ___In what city were you born? ____What high school did you attend? ____What is the name of your favorite movie? ____What is your mother's maiden name? ____On what street did you grow up? ____What was the make of your first car? ____What is your anniversary?
Answer to Verification Question: ____

Employment Status: ___Employed ___ FT Student ___ PT Student ___ Other

Occupation:__________________________ Employer:_________________

Number of hours a week you work? ___________

Are you currently able to work? ____Yes ____No If no, list dates out of work:____________________

Race (check one)

___White ___Asian ___Japanese ___Samoan ___Black/African American
___Asian Indian ___Korean ___Guamanlan or Chamorro ___Hispanic
___Chinese ___Vietnamese ___American Indian/Alaskan Native ___Filipino
___Native Hawaiian or other Pacific Island ___Other______________________
___I choose not to specify

Multi Racial (check one) ___Yes ___No ___Unknown

Ethnicity (check one)

___Hispanic or Latino ___Not Hispanic or Latino ___I choose not to specify

Preferred Language (check one)

___English ___Spanish ___American Sign Language ___Chinese ___French ___German ___Tagalog
___Vietnamese ___Italian ___Korean ___Russian ___Polish ___Arabic ___Portuguese ___Japanese
___French Creole ___Greek ___Hindi ___Persian ___Urdu ___Gujarati ___Armenian ___I choose not to specify

Date of Your Last Physical Examination:____________________

In case of emergency please contact_______________________ Phone:______________

Are you: __right handed __left handed __ambidextrous

Who referred you to our office? ____

Have you seen our advertising? ____

Do you currently smoke tobacco of any kind? ___Yes ___Former Smoker ___Never been a smoker

If yes, how often do you smoke: ___Current every day smoker ___Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

Not at all ___0 ___1 ___2 ___3 ___4 ___5 Very interested

Current medications, including frequency and dosage if known.

If there are no current medications check here_____

1. ________________________________ for ___________________________Start date ____________

2. ________________________________ for ___________________________Start date ____________

3. ________________________________ for ___________________________Start date ____________

4. ________________________________ for ___________________________Start date ____________

5. ________________________________ for ___________________________Start date _____________

List any known allergies you have had to any medications:

If no allergies, check here _______

1. ____
2. ____
3. ____

Briefly list your main health problems:

____

____

____

Has any doctor diagnosed you with Hypertension presently? ___Yes ___No

If yes, describe:

____

____

Has any doctor diagnosed you with Diabetes presently? ___Yes ___No

If yes, what kind? ___Type I ___Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c >9.0%

___Yes ___No ___Not sure

If yes, other comments regarding Diabetes:

____

____

Have you had an X-ray or CT scan or MRI of your low back in the past 28 days? ___Yes ___No

Current Complaints

The pain/problem began on or about:____________

The problem is the result of: ____Auto accident ___Accident at Work ___Other

How long have you been having the pain?
___ 1 week or less ___ 1 to 6 weeks ___ greater than 6 weeks but less than 3 months
___3 months to 1 year ___ over 1 year

Please list your areas of pain in order of severity. .

1. Area of Pain:____

2. Area of Pain:____

3. Area of Pain:____

4. Other:____

In general my symptoms are better in: __ AM __ Midday __ PM.
In general my symptoms are worse in: __ AM __ Midday __ PM.
__ symptoms do not change with the time of day.

Do you have night pain unrelated to movement? __Yes __No
Do you have constant pain unrelated to movement? __Yes __No
Are your symptoms / condition: ___ improving ___ unchanged ___ getting worse.

Have you seen specialist(s) for this condition? ___ Yes ___ No

Name:__________________________ Location ________________ Specialty____________________

Name:__________________________ Location_________________ Specialty____________________

Patient's Signature:______________________________
(Guardian If Minor)

COMEAU HEALTH CARE ASSOCIATES, PC

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CONSENT TO CHIROPRACTIC SERVICES

1. I,____,
authorize the performance upon myself of examinations and/or treatments performed by or under the direction of doctors, associates or assistants employed by Comeau Health Care Associates, PC.

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to, or different from those stated above, whether or not arising from presently unforeseen conditions that the doctors, associates or assistants employed by Comeau Health Care Associates, PC may consider necessary or advisable in the course of my health care.

3. The nature and purpose of the procedures, the possible alternatives, the risks involved, the possible consequences, and the possibility of complication have been explained to me by the doctors, associates or assistants employed by Comeau Health Care Associates, PC.

4. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the doctors, associates or assistants employed by Comeau Health Care Associates, PC.

Date:_____________________________Signed:_________________________________

Witness:_________________________Relationship:_______________________________

Comeau Health Care Associates

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To help us with total quality health care for our patients we would like to increase communication between our office and your medical doctor. If you would be interested in our new policy, please complete the authorization form, and we will periodically send an updated report to:

Primary Care Medical Doctor: ____

Address: ____

City/State: ____

Other Medical Doctors that need to be informed: ____

Address: ____

City/State: ____

Patient Please Initial: ___________