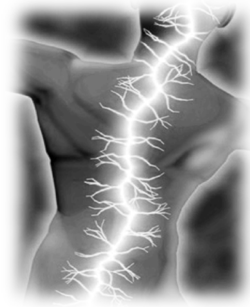
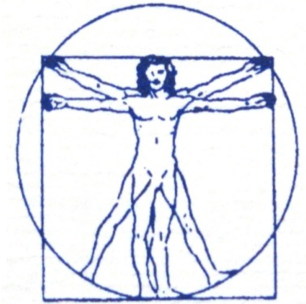
Dr. Jim Bremner, 515 Church St. Suite #1 Bound Brook, NJ 08805 Phone 908-251-3588



Patient Case History

Chiropractic has improved the health and lives of millions of men, women, and children… It's time you discover why!!!



Personal Information

Name ______________________________ DOB ______________

Address ______________________________ SSN ______________

City ______________________________ State __________ Zip______________

Cell (______)______________ Home (______)______________ Work (______)______________

E-Mail ______________________________ Male ☐ Female ☐

Employer ______________________ Occupation ______________________

Marital Status S☐ M☐ D☐ W☐ Name of Spouse ______________________

No. of Children ________ Names and Ages ______________________

Emergency Contact Name ______________________ Phone (______)______________

Who may thank for referring you today? ______________________

Name of insurance company ______________________ Policy # ______________

Health Information

Reason for your visit today ______________________

Date of Onset ______________ Have you had previous Chiropractic Care? Yes ☐ No ☐

Chiropractor's Name ______________________ Date of Last Visit ______________

Reason for previous Chiropractic Care ______________________

Have you had this condition before? Yes ☐ No ☐ When? ______________

Is your condition related to an auto accident? Yes ☐ No ☐ When? ______________

Is your condition related to a work accident? Yes ☐ No ☐ When? ______________

Is your condition STAYING THE SAME ☐ GETTING BETTER ☐ GETTING WORSE? ☐

Does your condition interfere with SLEEP ☐ DAILY ROUTINE ☐ WORK ☐ OTHER? ☐

Previous treatment for your condition ______________________

What makes your condition BETTER? ______________________

What makes your condition WORSE? ______________________

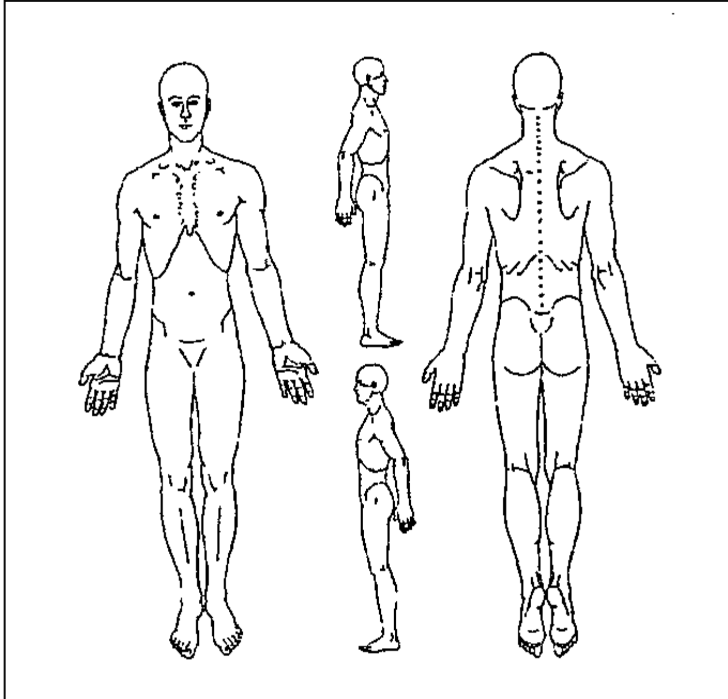
Medications you are currently taking: PAIN ☐ DIABETES ☐ HEART ☐ ASPIRIN ☐
SLEEPING ☐ MUSCLE RELAXER ☐ ANTI-DEPRESSANT ☐ BIRTH CONTROL ☐

Surgeries and Dates ______________________

Injuries and Fractures and Dates______________________

Use the following letters on the diagram to indicate the type of altered sensations you are experiencing.

A=ACHE	**SH=SHARP**
B=BURN	**ST=STABBING**
E=ELECTRIC	**SF=STIFFNESS**
N=NUMBNESS	**TG=TINGLING**
M=MUSCLE SPASM	**TT=TIGHTNESS**



Rate Your Level of Pain
No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Pain

EXERCISE: None ☐ 1-3 Times/Week ☐
3-5 Times/Week ☐ 5-7 Times/Week ☐

Check any of the following conditions you have presently or have had in the past:

☐ Allergies	☐ Digestive Trouble
☐ Anemia	☐ Dizziness
☐ Arthritis	☐ Female Problems
☐ Asthma	☐ Headaches
☐ Back Pain	☐ Heart Disease
☐ Cancer	☐ Male Problems
☐ Chest pain	☐ Menstrual Cramps
☐ Confusion	☐ Mental Disorder
☐ Depression	☐ Multiple Sclerosis
☐ Diabetes	☐ Neck Pain
☐ Epilepsy	☐ Nervousness
☐ Fatigue	☐ Prostate Trouble
☐ Foot Pain	☐ Respiratory Trouble
☐ Ankle Pain	☐ Scoliosis
☐ Knee Pain	☐ Sinus Problems
☐ Hip Pain	☐ Skin Problems
☐ Hand Pain	☐ Stress
☐ Wrist Pain	☐ UTI
☐ Elbow Pain	☐ Weight Gain/Loss
☐ Shoulder Pain	Other ________________

DIET: Does your diet include the following?

Fast Food	Yes ☐	No ☐
Food Craving	Yes ☐	No ☐
Fruits	Yes ☐	No ☐
Red Meat	Yes ☐	No ☐
Sweets	Yes ☐	No ☐
Vegetables	Yes ☐	No ☐
Water	Yes ☐	No ☐

Rate Your Diet: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

HABITS: Smoking packs/day _____ **Caffeine** cups/day _____ **Alcohol** amount/day _____ **Soda** oz/day _____

Family Physician Name ______________________________________ Date of Last Visit _____________

Reason for care ____

Date of Last Physical Exam and by Whom ____

As a result of Chiropractic Care I would like to: (Please Check All that Apply)

Feel Better ☐ Have a Healthier Spine ☐ Have a Healthier Body ☐ Live a Healthier Lifestyle ☐

Agreement

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me, the policy holder. I also understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment that any fess for professional services rendered me will be immediately due and payable.

Patient's Signature____ Date ___________________

Parent or Guardian Signature___________________________________ Date ___________________