ALTERNATIVE INTEGRATED MEDICAL SERVICES, LLC

CONFIDENTIAL PATIENT CASE HISTORY **DATE**_____

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

Who referred you to this office? _____ How else did you hear about us? _____

GENERAL PATIENT INFORMATION

Name_____ Date of Birth _____ Sex: Male Female
Address_____ City _____ State _____ Zip _____
Home Ph _____ Cell Ph _____ Work Ph_____
E-mail address: (home) _____ (work) _____
What is preferred contact method? Home Phone Cell Phone Work Phone Home e-mail Work e-mail
Emergency Contact Name _____ Phone # _____

Marital Status: Married Single Legally Separated Divorced Widowed
Children: YES NO Ages: _____

Preferred Language ( ) English ( ) Spanish ( ) Other ( ) I choose not to specify
Race (Check one) ( ) White ( ) Black/African American ( ) American Indian/Alaskan Native
( ) Asian ( ) Native Hawaiian/Other ( ) Other ( ) I choose not to specify
Ethnicity ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) I choose not to specify

Occupation: _____ Employer: _____
Insurance Company Name: _____ ID #: _____
Name of Insured: _____ Relationship to Insured: _____ Insured's DOB _____

Major Complaint(s) in order of significance to you, and date of onset:

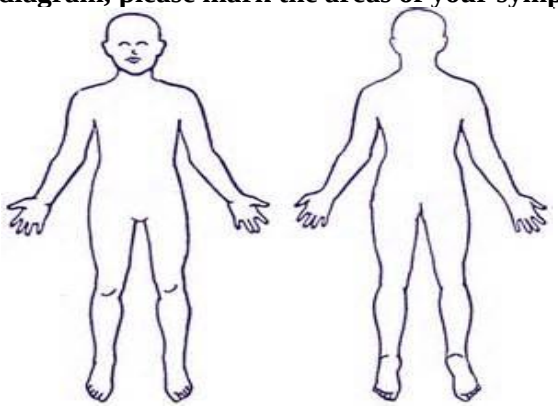
1. _____ Date of Onset: _____
2. _____ Date of Onset: _____
3. _____ Date of Onset: _____
4. _____ Date of Onset: _____

Have you had this or similar condition in the past? YES NO If yes, when? _____
How do these conditions impair your daily activities (work, sleep, recreation, etc.)? _____
Other doctors or therapists who have treated this condition: _____
What do you think caused this condition? _____

Have you received any of the following THIS YEAR? Chiropractic YES NO If yes, how many visits? _____
Physical Therapy? YES NO If yes, how many visits? _____ Acupuncture? YES NO If yes, how many visits? _____

Have you been in an auto accident? YES NO If yes, when? _____ Do you have an open claim? YES NO
Have you had a work-related injury? YES NO If yes, when? Do you have an open workman's comp. claim? YES NO

On the diagram, please mark the areas of your symptoms:



Patient Name: _____