



Dr. Marshall D. Rothman
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Confidential Patient History

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to best understand your health problems, please complete this form neatly, accurately, and completely. **Thank You.**

Personal Information

Patient Name: _____ Today's Date: _____
Address: _____ SS# _____ - _____ - _____
_____ Birth date _____
(City) (State) (Zip Code) Age _____
Home Phone #: (_____) _____ Cell Phone or Pager #: (_____) _____
Marital Status **S M D W** # of Children _____ Ages _____
Email Address _____

Employer Information

Occupation _____ Employer _____
Address _____
Work Phone #: (_____) _____

Spouse's Information

Spouse's Name _____
Occupation _____ Employer _____
Work Phone #: _____ Nearest Relative & phone# _____

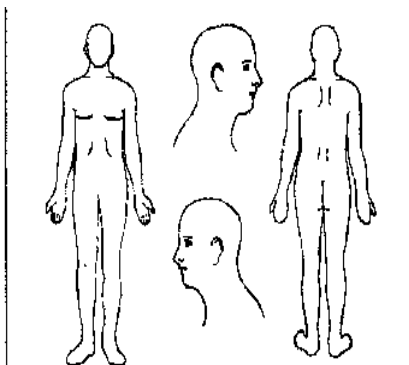
Reason for your visit today

List present complaints, injuries and the duration of your problem

1. (Date of Onset) _____

2. (Date of Onset) _____

3. (Date of Onset) _____



Please mark areas of problem on the figures above

Please rate (Circle) the pain on a scale of 1-10 0 = No Pain 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Describe the pain or condition:

___ sharp ___ dull ___ intermittent ___ localized ___ aching
___ stabbing ___ constant ___ radiating ___ burning ___ throbbing
___ numbness ___ tingling ___ shock-like ___ other _____

Any other details that might help the doctor? _____

Have you ever been to a Chiropractor before? **YES** or **NO**

How did you hear about this office? _____

Have you had any surgery, accidents (broken bones), major illnesses, or injuries? If so, please give dates and describe

Is it possible that you are **pregnant**? **YES** or **NO**

Do you have health insurance? **YES** or **NO (If Yes, Please give insurance card to front desk)**

Are you on Medicare? **YES** or **NO (If Yes, Please give Medicare card to front desk)**

Have you seen another professional for this condition? **YES** or **NO**

If so, then who? _____

Are you currently under a physician's care for this or any other reason? **YES** or **NO**

If yes, please explain? _____

Are you currently taking any medications or nutritional supplements? **YES** or **NO**

If so, please list _____

Habits

___ Smoking pack/s/day___ ___ Alcohol drinks/week___
___ Coffee/Caffeine cups/day___ ___ High Stress Level Reason_____

Exercise: Light Moderate Heavy Daily Weekly Sporadically None at all

Work Activity: ___ Sitting ___ Standing ___ Light Labor ___ Heavy Labor ___ At Computer

Sleep Habits: ___ On stomach ___ On back ___ On side **Quality:** ___ Good ___ Poor



Health Makes You Smile!