**Garabo Chiropractic Health Center, P.C.**
**James Garabo, DC**
**1457 Raritan Road, Suite 204**
**Clark, NJ 07066**

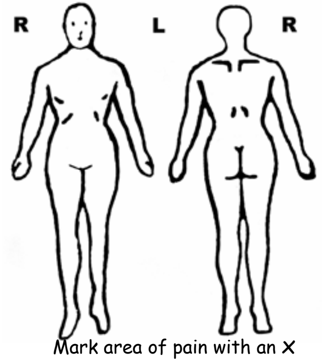
# Confidential Patient Case History

Name___________________________________ Who may we thank for referring you? ______________

Birthdate___________ Age ________ Occupation____________________ Marital Status: M S W D

Spouse's Name____________________ # Of Children _________

How long has it been since you really felt good? __________________________________




What is your major complaint? _______________________________________
_______________________________________________________________

How long have you had this condition? _________________________________

Is your condition due to an auto accident or job related injury? YES__ or NO__

Have you had this or similar conditions in the past? ______ When? ___________

Other doctors who treated this condition? _____________________________

**Health Information**

Who is your Primary Care Physician? _________________________________________________________

Have you had previous Chiropractic care? Yes No When? __________ Dr.'s Name_________________

What was your major complaint?_________________ How long were you treated? ___Months _____ visits

Is there any chance you may be pregnant? ___________________

Have you ever been diagnosed with Cancer? _________ If so, what type? ________________________

I authorize James Garabo and whomever he may designate as his assistants to perform Chiropractic adjustments, treatments, and procedures upon, __________________________________________.
Patients name

I further consent to X-ray examinations, laboratory procedures, consulting services, diagnostic procedures rendered in conjunction with adjustments, treatments and procedures.

**Your health information will be kept confidential in compliance with our HIPAA policies.** Any information that we collect about you on this form will be kept confidential in our office unless otherwise authorized. If a claim is submitted to Medicare or other insurance company, you authorize the release of requested information in order to process the claim. In addition, if the doctor feels it necessary, he may discuss your health information with your other medical care providers.

Date: ______ Signed: _______________________________Guardian or Spouse's Signature_____________

Witness: ____________________________________________

**Below is a list of diseases and treatments that may seem unrelated to the purpose of you appointment. However, these questions must be answered carefully as these problems can affect the overall course of chiropractic care.**

If you have, or have had, any of the following, please check all that apply:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Smallpox
- ☐ asthma
- ☐ Polio
- ☐ Carpal Tunnel Syndrome
- ☐ Arthritis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hernia
- ☐ Thyroid
- ☐ Measles
- ☐ Eczema
- ☐ Mental Disorders
- ☐ Anemia
- ☐ Stroke
- ☐ Heart Disease
- ☐ Whooping Cough
- ☐ Allergy Shots
- ☐ AIDS/HIV
- ☐ Sinus Trouble
- ☐ Digestive Disorders
- ☐ Numbness
- ☐ Headaches
- ☐ Backache
- ☐ TMJ/Clicking Jaw
- ☐ Miscarriage
- ☐ Shingles
- ☐ Osteoporosis
- ☐ High Blood Pressure
- ☐ Tuberculosis
- ☐ Concussion
- ☐ _____________
- ☐ Fracture/Broken Bones

The following family members have the same or similar problems as I do:

☐ Father ☐ Mother ☐ Sister/brother ☐ Spouse ☐ Child ___________________________

Date of last physical exam and Doctor's name:

__________________________________________________

List **ALL TYPES** of surgeries you have had and the dates that they occurred: _______________________

_____________________________________________________________________________________

Please list **all medications/nutritional supplements** you are currently

taking:__________________________

_____________________________________________________________________________________

Allergies:

_____________________________________________________________________________

_____________________________________________________________________________________

**Daily Habits:**

How much water do you drink daily? _______________________________________________________

What type of exercise do you do? _____________________________ How often?__________________

What do your daily work habits include? (Ex.: sitting, standing, heavy lifting) ________________________

_____________________________________________________________________________________

Do you smoke? ☐ No ☐ Yes How much per day? _____________________________________________

How much alcohol do you consume on a weekly basis?

____________________________________________

How much coffee or caffeinated beverages do you consume on a daily basis?

__________________________

**I have accurately disclosed all information pertaining to my past/present health status on both sides of this history.** ___________ __________

Initial Date