Dr. Durlan Castro, D.C., B.S., A.R.T., 1056 Jericho Turnpike, Smithtown, New York 11787
Phone: (631) 486-9100 * Fax: (631)486-9102 * www.drdurlancastro.com

Welcome to our office.

Confidential Patient Case History

Complete ALL parts to this questionnaire. This confidential history will be part of your permanent record. Thank You.

Patient Information:

Date: _____

Patient Name: _____ DOB: ___/___/___ Sex: M F

If under the age of 18, Parent/Guardian Name: _____

Address: _____ City: _____ Zip: _____

Social Sec: _____ Marital Status: S M D W Children Ages:_____

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___)_____

E-Mail Address: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Who referred you to our office? _____

Patient Condition:

Reason for THIS visit: _____

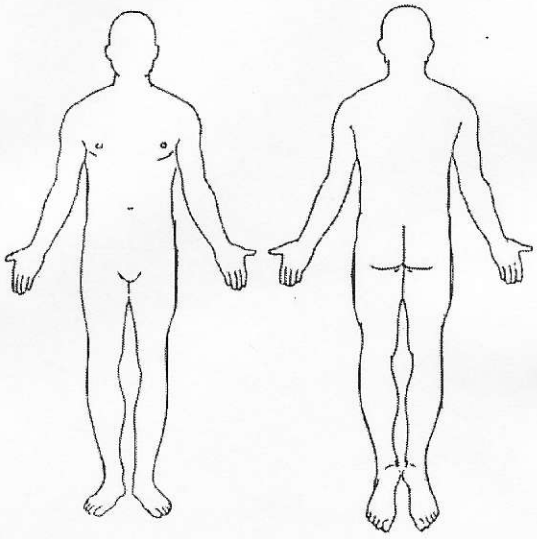
When did your symptoms appear? _____ Is this condition getting progressively worse? Y N

Any other Health Care providers treating you for this? _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain): _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Mark an **"X"** on the picture where you continue to have pain or tightening:



How often do you have this pain? (Please mark all that apply)
☐ Constant ☐ Come and go ☐ Daily
☐ Weekly ☐ Wake up ☐ End of day

Does it interfere with your:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying down

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What treatment have you already received for your condition? □ Medication □ Surgery

□ Physical Therapy □ Chiropractic □ Other _____

What other doctor(s) have treated you for this condition? _____

MRI: _____ X-ray: _____

Place an **X** on "**Yes**" or "**No**" to indicate if you have or have had any of the following:

Diabetes	Yes	No	High Cholesterol	Yes	No	Polio	Yes	No
Emphysema	Yes	No	Kidney Disease	Yes	No	Prostate Problem	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No	Psychiatric Care	Yes	No
Fractures	Yes	No	Migraines	Yes	No	Rheumatoid Arthritis	Yes	No
Goiter	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
Hepatitis	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Hernia	Yes	No	Pacemaker	Yes	No	Tumor	Yes	No
Headaches	Yes	No	Parkinson's Disease	Yes	No	Ulcers	Yes	No
Herniated Disc	Yes	No	Pinched Nerve	Yes	No	Other _____		

EXERCISE	**WORK ACTIVITY**	**HABITS**	
None	Sitting	Smoking	Packs/Day _____
Moderate	Standing	Alcohol	Drinks/Week _____
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day _____
Heavy	Heavy Labor	High Stress Levels	Reason _____

MEDICATIONS	**ALLERGIES**	**VITAMINS**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you pregnant? Yes No If Yes, due date: _____

Injuries/Surgeries you have had:

	Description	Date
Falls	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

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General Health Insurance:

Insurance Company Name: _____ Phone #: _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship: □ Self □ Spouse □ Child □ Other: _____

Secondary Health Insurance:

Insurance Company Name: _____ Phone #: _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship: □ Self □ Spouse □ Child □ Other: _____

No-Fault/Worker's Compensation Insurance:

Insurance Company Name: _____

Address: _____ Phone #: _____

Claim # or Carrier Case #: _____ Policy #: _____

Date of Accident: _____ Describe accident or injury: _____

_____

Attorney Name and Phone (if applicable): _____

I hereby authorize this office to release any information requested by my insurance company to document any claim for benefits. I understand that I am responsible for full payment of all charges for my treatment. Services are payable at the time rendered.

_____ _____

Patient or Guardian Signature Date