CASE HISTORY

Name Date Height Weight

Address City State Zip

Home Phone Home Fax Cell # Email Address

Age Birthdate / / Sex ☐ M ☐ F Status ☐ M ☐ S ☐ W ☐ D No. Children Soc. Sec. # Driver Lic. #

Occupation Employer Years Employed

Employer's Address City State Phone

Spouse's Name Occupation Employer

Person responsible for this account Referred by

What is your major complaint?

Other complaints:

How long have you had this condition? Have you had this or similar conditions in the past?

What activities aggravate your condition?

Is this condition: ☐ Getting progressively worse? ☐ Constant? ☐ Comes and goes?

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other

How long has it been since you really felt good?

List surgical operations:

Are you taking any medications? ☐ Yes ☐ No What kind?

Any non-prescription drugs? ☐ Yes ☐ No What kind?

Other doctors seen for this condition: ☐ MD ☐ DC ☐ DO ☐ DDS Doctor's Name

Diagnosis ☐ X-rays ☐ Urinalysis ☐ Blood Tests ☐ Other

Treatment: ☐ Medication ☐ Physiotherapy

Results Length of time under care

Were you off work? ☐ Yes ☐ No If yes, how long? Have you returned to your same job? ☐ Yes ☐ No If not, why?

INSURANCE INFORMATION: Are you covered by Medicare? ☐ Yes ☐ No Medicare # State Insurance Aid? ☐ Yes ☐ No

Do you have any group, union or personal health and accident insurance? ☐ Yes ☐ No

Primary Insurance Co. Claim # Group #

Address Phone Agent

Additional Insurance Co. Claim # Group #

Address Phone Agent

Is your condition due to: ☐ Accident? ☐ Illness? ☐ Other

ACCIDENT INFORMATION: Did your accident occur while at work? ☐ Yes ☐ No Were you involved in an automobile accident? ☐ Yes ☐ No

Date Time Injury reported to employer? ☐ Yes ☐ No Name of Supervisor

Description of accident:

Were you injured? ☐ Yes ☐ No If yes, how?

Location

Were you unconscious? ☐ Yes ☐ No ☐ Fractures? ☐ Cuts? ☐ Abrasions? ☐ Bruises?

Patient taken to Hospital for treatment

Confined to hospital for days hours Name of hospital doctor

Haver you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe

Do you have an attorney? ☐ Yes ☐ No Name & Address

I clearly understand and agree that all services rendered to 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, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

IMPORTANT: Please check (X) all present symptoms.

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R - L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat _____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumbar
  - ☐ Sacroilliac
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
  - ☐ walking
- ☐ Pain relieves when _____
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R - L)
- ☐ Pain in hip joint (R - L)
- ☐ Pain down leg (R - L)
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R - L)
- ☐ Pins & needles in legs (R - L)
- ☐ Numbness of leg (R - L)
- ☐ Numbness of feet (R - L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R - L)
- ☐ Swollen feet (R - L)

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer _____
- ☐ Discharge
- ☐ Menopause _____
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep _____
- ☐ Loss of sleep _____ hrs./night
- ☐ Loss of weight _____ lbs.
- ☐ Gain weight _____ lbs.
- ☐ Coffee _____ cups/day
- ☐ Tea _____ cups/day
- ☐ Cigarettes _____ pack/day
- ☐ Other _____
- ☐ Diabetes
- ☐ Hypoglycemia

REMARKS: