Patient Case History

Name _____ Date ____/____/____

Home Phone ( ) _____ Cell #

Date of Birth ___/___/___ Age _____ Sex: M F

Address _____
Street City State Zip

Occupation _____ How many years? _____
Employer _____ Work Phone ( ) _____
Employer Address _____
Street City State Zip

Marital Status: S M W D Spouse Name _____ # of Children _____
Referred by _____ Spouse Date of Birth ___/___/___

Insurance Information: *** Please give Insurance Card to Receptionist to photocopy*

Chief Complaint

Is your condition related to an auto accident? _____ No _____ Yes — **Please Notify Receptionist
Is your condition caused by a job injury? _____ No _____ Yes — **Please Notify Receptionist
What is your major complaint? _____

Date these symptoms first appeared? ____/____/____

Have you had these symptoms before? Yes No If yes, when? _____

Have you seen another doctor for this condition? Yes No If yes, when? ____/____/____

Doctor's name _____ Diagnosis _____
Does bed rest give you any relief of pain? Yes No

Family Doctor _____ Phone Number _____

Medications/Supplements:
1. _____
2. _____
3. _____
4. _____
5. _____

Hospitalizations/Surgeries/Fractures/Accidents/Implants:
1. _____
2. _____
3. _____
4. _____
5. _____

(If more room needed please use back of paper)

Most insurance policies provide Chiropractic care coverage. Benefits vary from company to company and policy to policy. We do accept certain insurance assignments but all insurance assignments must be approved in advance. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will help prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

Patient's signature _____ Date ____/____/____

PAIN DRAWING

Name: _____ Todays Date: _____

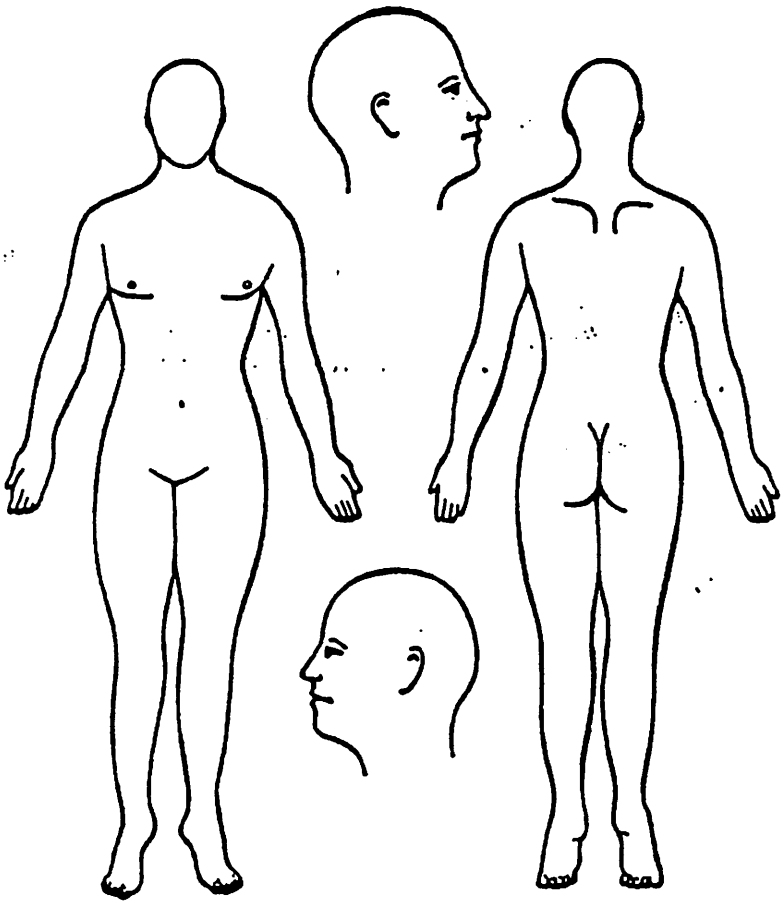
Examiner: _____

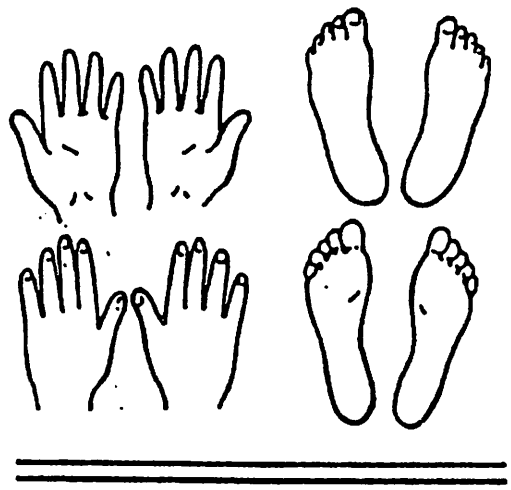
TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols(s) listed below.

Ache > > > >	Numbness = = = =	Pins and Needles o o o o
> > > >	= = = =	o o o o
Burning x x x x	Stabbing / / / /	Throbbing ~ ~ ~ ~
x x x x	/ / / /	~ ~ ~ ~





SEVERITY OF PAIN

List region of pain and circle severity number. (1 = least, 10 = greatest)

ex. Neck
1 2 3 (4) 5 6 7 8 9 10

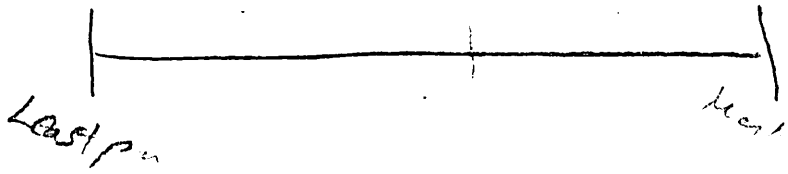
1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

5. _____
1 2 3 4 5 6 7 8 9 10



Please check if you had in the past or presently have any of the following:

- ☐ Loss of weight
- ☐ Pain awakens you from sleep
- ☐ Pain on coughing
- ☐ Pain on sneezing
- ☐ Pain on straining
- ☐ Numbness _____
- ☐ Pins & Needles_____
- ☐ Herniated discs
- ☐ Degenerative discs
- ☐ Sciatica
- ☐ Low back pain
- ☐ Neck pain/ stiff
- ☐ Pain between shoulder blades
- ☐ Bursitis/ tendonitis
- ☐ Foot/knee trouble
- ☐ Hip problems
- ☐ Swollen joints
- ☐ Headaches
- ☐ Migraines
- ☐ Double vision
- ☐ Dizziness
- ☐ Fatigue
- ☐ Loss of sleep
- ☐ Depressed/anxiety
- ☐ Change in bowel movements
- ☐ Constipation
- ☐ Vomiting/ nausea
- ☐ Indigestion
- ☐ Pain in abdomen
- ☐ Pain in chest
- ☐ Chest palpitations
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting up blood
- ☐ Hoarseness
- ☐ Wheezing
- ☐ Out of breath
- ☐ Blood in urine
- ☐ Blood in stool
- ☐ Burning urination
- ☐ Inability to control bladder
- ☐ Swollen ankles
- ☐ Poor circulation
- ☐ Enlarged glands
- ☐ Cancer
- ☐ Stroke
- ☐ Mini strokes TIA
- ☐ High blood pressure
- ☐ Pace maker
- ☐ Diabetes
- ☐ Kidney stones
- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Varicose veins
- ☐ Heart problems
- ☐ Lung problems
- ☐ Asthma
- ☐ Emphysema
- ☐ Thyroid trouble
- ☐ Allergies
- ☐ Sinus trouble
- ☐ Stomach problems
- ☐ Ulcers
- ☐ Gallbladder trouble/ stones
- ☐ Liver trouble
- ☐ Colitis
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Polio
- ☐ TB
- ☐ Chicken pox
- ☐ Appendicitis
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Anemia
- ☐ Urinary tract infections
- ☐ Scoliosis
- ☐ Muscle/ ligament tears
- ☐ Right handed
- ☐ Left handed
- ☐ Eye problems
- ☐ Deafness
- ☐ Other_____

_____

_____

_____

FEMALE

- ☐ Lumps in breast
- ☐ Hysterectomy
- ☐ Are you pregnant?
- ☐ Last gyn exam date _____
- ☐ Birth control pill
- ☐ Medication for cycle
- ☐ Breast implants
- ☐ Menopause since____

MALE

- ☐ Prostate Trouble
- ☐ Testicular lumps

Indicate how often:

- ☐ Tobacco ___yrs
- ☐ Coffee/tea ___day
- ☐ Meals ____/day
- ☐ Water ____/day
- ☐ Sleep ____hrs
- ☐ Exercise how often and what type?_____

_____

Please indicate if a member of your immediate family & grandparents have had the following:

- ☐ Cancer _____
- ☐ Stroke _____
- ☐ Hi/low blood pressure _____
- ☐ Heart attack _____
- ☐ Heart problems
- ☐ Diabetes _____
- ☐ Asthma _____
- ☐ Thyroid problems

_____

- ☐ Kidney problems
- ☐ Arthritis
- ☐ Multiple sclerosis
- ☐ Gout
- ☐ Other_____

_____

_____