CASE HISTORY

Name_____ Date_____
Address: _____ City_____ State____ Zip_____
Home Phone _____ SSN_____ Drivers Lic.#_____
Cell Phone_____ E-mail _____
Age_____ Birthdate_____ Sex M F Status M S W D No. of Children _____
Occupation _____ Employer _____ Yrs Employed _____
Employer's Address _____ City_____ State _____ Zip_____
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? Y / N
What activities aggravate your condition? _____
Is this condition getting progressively worse? ☐ YES ☐ NO 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? ____ How long? _____ Have you returned to the same job? ____ 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 insurance? ☐ YES ☐ NO
Insurance Company_____ Member ID _____ Group #_____
Address _____ Phone _____

Is your condition due to an accident? ☐ YES ☐ NO ☐ Illness ☐ Other _____
Did your accident occur while at work? ☐YES ☐ NO Were you involved in an auto accident? ☐ YES ☐ NO
Date_____ Time _____ Injury reported to employer? ☐ YES ☐ NO Supervisor Name_____
Description of accident? _____
_____
How were you injured? _____
Location _____ Were you unconscious? _____
Fractures _____ Cuts _____ Abrasions _____ Bruises_____
Were you taken to the hospital? ☐ YES ☐ NO Name of Hospital _____
Confined to hospital for _____ days _____ hours. Name of hospital Dr_____
Have you had any other personal injury or accident? ☐ Past year ☐Past 5 years ☐Over 5 years ☐ None
Do you have an attorney? ☐ YES ☐ NO Attorney Name and 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.

_____ _____
Patient's Signature (Guardian's Signature if minor patient) 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

ARMS AND 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)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength

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

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 you can't eat
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:
- Low back pain
- Upper lumbar
- Lower lumbar
- Sacroiliac
- Low back pain is worse when:
  - Working
  - Lifting
  - Stooping
  - Standing
  - Sitting
  - Bending
  - Coughing
  - Lying down (sleeping)
  - Walking
  - Pain relieved when _____
  - Slipped disk
  - Low back feels out of place
  - Muscle spasms
  - Arthritis

HIP, LEGS, AND FEET:
- Pain in buttocks
- Pain in hip joint
- Pain down leg
- Pain down both legs
- Knee pain
  - Inside
  - Outside
- Leg cramps
- Cramps in feet
- Pins and needles in legs
- Numbness of leg
- Numbness of toes
- Feet feel cold
- Swollen ankles
- Swollen feet

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

MEN ONLY:
- Urinary frequency _____
- Difficulty in starting
- Night urination
- Prostrate pain/swelling

GENERAL:
- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep_____ hrs/night
- 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: _____
_____
_____
_____
_____
_____

Patient Signature _____
(Guardian signature if minor patient)

Date _____