CASE HISTORY

Name ______________________ Date ______
Address ______ City ______ State ______ Zip ______
Telephone ______ Social Security # ______ Driver Lic. # ______
Age ______ Birthdate ______ Sex ______ Status M S W D No. Children ______
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? 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? ______ What kind? ______
Any non-prescription drugs? ______ 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? ______ If so, how long ______ Have you returned to your 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 and accident insurance? Yes ☐ No ☐
Name of Insurance Company ______ Claim # ______ Group # ______
Address ______ Phone ______ Agent ______
Additional Insurance Company ______ Claim # ______ Group # ______
Address ______ Phone ______ Agent ______
Is your condition due to an 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? ______ How? ______
Location ______
Were you unconscious? ______ Fractures ______ Cuts ______ Abrasions ______ Bruises ______
Patient taken to ______ Hospital for ______ Treatment.
confined to hospital for ______ Days ______ Hours. Name of hospital doctor ______
Have 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
- ☐ Diarrea
- ☐ Hemorroids

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 might be 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:

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