CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Social Security # _____ Driver Lic. # _____
Age _____ Birthdate _____ Sex _____ Status M S W D No. of 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 you 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?
Name of Insurance Company _____ Claim # _____ Group # _____ Agent _____
Address _____ Phone _____
Additional Insurance Company _____ Claim # _____ Group # _____ Agent _____
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 automobile accident? ☐ YES ☐ NO
Date _____ Time _____ Injury reported to employer Name of supervisor _____
Description of accident _____

Were you injured? _____ How _____
Location _____
Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____
Patient taken to _____ Hospital for _____
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 ☐
Do you have an attorney? ☐ YES ☐ NO 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. I also agree that if I terminate my care and treatment, any fees for professional services rendered to me will become 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 bother 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 lett
- ☐ 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 and needles in arms
☐ Sensation of pins and 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 can't eat _____
☐ Nausea
☐ Gas
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids

LOW BACK:

☐ Low back pain
☐ Upper lumhar
☐ Lower lumbar
☐ Sacroiliac
☐ Low back pain is worse when:
☐ Working
☐ Liftinng
☐ 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 do you think you are 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's Signature _____ Date _____