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: ____

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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:

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