CASE HISTORY

Name: _____ Date: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____
E-mail: _____ Social Security #: ___/___/___ Driver License #: _____ State: _____
Age: _____ Birth date: _____ Sex: ☐M ☐F Status: ☐M ☐S ☐W ☐D # of Children: _____
Occupation: _____ Employer: _____ Years Employed: _____
Employer's Address: _____ City: _____ 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? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? ☐Yes ☐No ☐Constant ☐Comes and goes
Is this condition interfering with your work: ☐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 nonprescription 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: _____ Physical Therapy: _____
Results: _____ Length of time under care: _____
Were you off work? _____ How long? _____ Have you returned to your same job? _____ 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 of injury? _____ ☐Loss of consciousness ☐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 five years ☐Over five 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 _____

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Lightheadedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in the 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

MIDBACK:
- ☐ Midback pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

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 relieves when _____
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

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

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Dietary restrictions _____

_____

- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

HIPS, LEGS, & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Pain down both legs (R-L)
- ☐ 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)

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depression
- ☐ Generally feel run down
- ☐ Normal sleep _____ hours/night
- ☐ Loss of sleep _____ hours/night
- ☐ Loss of weight _____ pounds
- ☐ Weight gain _____ pounds
- ☐ Coffee _____ cups per day
  - ☐ caffeinated
  - ☐ decaffeinated
- ☐ Tea _____ cups per day
- ☐ Cigarette _____ packs per day
- ☐ Other _____
- ☐ Diabetes
- ☐ Hypoglycemia

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer _____
- ☐ Discharge
- ☐ Menopause _____ (when)
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you might be pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain or swelling

REMARKS:

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