CONFIDENTIAL PATIENT CASE HISTORY

NAME: ____

ADDRESS: ____

HOME PHONE: ________________ WORK PHONE: ________________ AGE ____________

SOCIAL SECURITY #: ______________ BIRTHDATE: ______________ SEX: MALE FEMALE

EMPLOYER NAME/ADDRESS ____

PRIMARY INSURED: ________________________ RELATIONSHIP ________________

INSURANCE CO. NAME/ADDRSS/PHONE/POLICY# ______________________________

____

____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? YES NO
WERE YOU INJURED ON THE JOB? YES NO
WERE YOU IN AN AUTOMOBILE ACCIDENT? YES NO
WAS A POLICE REPORT MADE? YES NO
WERE YOU INJURED OR HAVE AN ACCIDENT AT HOME? YES NO
WERE YOU INJURED IN ANY OTHER TYPE OF ACCIDENT? YES NO

**COMPLETE DESCRIPTION OF HOW ACCIDENT/INJURY HAPPENED: ________________

____

INJURY
**EXACT ACCIDENT DATE: ____________ TIME: __________ PLACE: ________________

**LIST ALL DAYS MISSED FROM WORK DUE TO THIS ACCIDENT/INJURY: ____________

____

*DO YOU WANT A REPORT SENT TO YOUR ATTORNEY? IF SO LIST NAME AND ADDRESS:

____

PLEASE DESRIBE PRICIPLE HEALTH PROBLEM FOR WHICH YOU CAME TO THIS OFFICE:

____

HAVE YOU HAD THIS OR SIMILER CONDITION IN PAST? DESCRIBE ________________

____

HOW LONG HAVE YOU HAD THIS CONDITION/PAIN? ______________________________

HAVE YOU BEEN IN HOSPITAL FOR YOUR PAIN PROBLEM? YES NO

WHEN/WHERE?: ____

****LIST ALL DOCTORS YOU HAVE SEEN FOR THIS CONDITION/ACCIDENT/INJURY:

____

LIST ANY OTHER DOCTORS YOU ARE PRESENTLY BEING TREATED BY AND FOR WHAT CONDITION: ______________________________

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: ______________________________

LIST DATES OF ALL SURGERY AND/OR UNUSUAL DISEASES/ILLNESSES: ______________________________

____

HAVE YOU EVER HAD NECK, BACK OR KNEE SURGERY? YES NO

****HAVE YOU HAD ANY DIAGNOSITIC STUDIES OTHER THAN X-RAYS?

A.	CAT SCAN	YES	NO	DATE/PLACE ______________
B.	MYELOGRAM	YES	NO	DATE/PLACE ______________
C.	EMG	YES	NO	DATE/PLACE ______________
D.	DISCOGRAM	YES	NO	DATE/PLACE ______________
E.	OTHER	YES	NO	DATE/PLACE ______________

CHECK APPROPRIATE BOX FOR ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOW OR HAVE HAD IN THE PAST. DO NOT CHECK IF IT DOES NOT APPLY TO YOU.

O - OCCASIONAL F - FREQUENT C - CONSTANT

O F C

GENERAL
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness/depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

MUSCLE & JOINT
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain or stiffness
- ☐ ☐ ☐ Pain between shoulders
- Pain or numbness in:
  - ☐ ☐ ☐ Shoulders
  - ☐ ☐ ☐ Arms
  - ☐ ☐ ☐ Elbows
  - ☐ ☐ ☐ Hands
  - ☐ ☐ ☐ Hips
  - ☐ ☐ ☐ Legs
  - ☐ ☐ ☐ Knees
  - ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tail bone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

GENITO-URINARY
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Inability to control kidneys
- ☐ ☐ ☐ Kidney infection or stones
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostrate trouble
- ☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excessive menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopausal symptoms
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal Discharge
- ☐ Yes ☐ No Are you pregnant?

GASTRO-INTESTINAL
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Distension of abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gall bladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

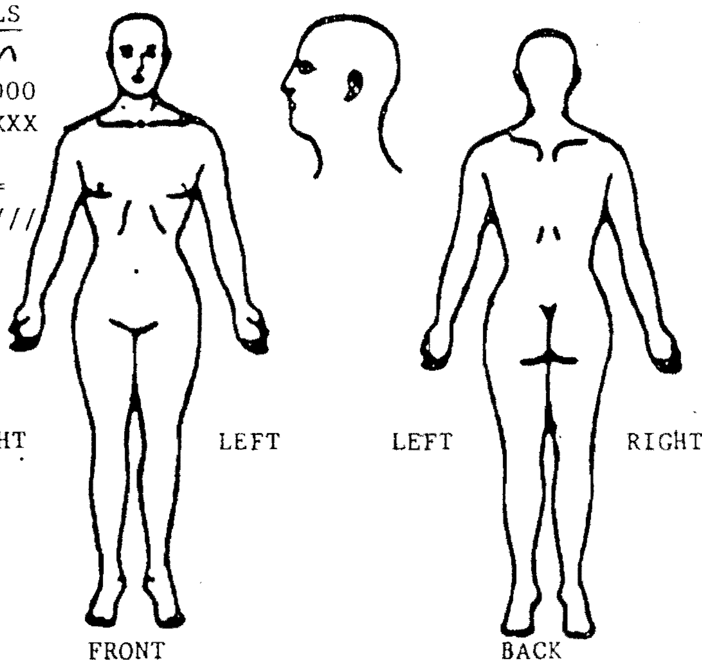
CARDIO-VASCULAR
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood press
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heart beat
- ☐ ☐ ☐ Slow heart beat
- ☐ ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ ☐ Chect pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

MARK AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE APPROPRIATE SYMBOLS.

PAIN SYMBOLS

ACHE- ^^^
NUMBNESS-000
BURNING-XXXX
NEEDLES & PINS-= = =
STABBING-///



HOW BAD IS YOUR PAIN RIGHT NOW?
CIRCLE: MILD MODERATE SEVERE NO PAIN
OTHER: ______________________________