Case History

Patient Name: _____ Sex: M ( ) F ( ) Date: _____

Address: _____ City: _____ State: _____ ZIP: _____M ( ) S ( ) D ( ) W ( )

Telephone (H): _____ (C):_____ Email: _____

Social Security #: _____ Driver Lic. #_____Birthdate: _____No. Children: _____

Occupation: _____ Employer: _____ Years Employed: _____

Employers Address: _____ City: _____ State: _____ ZIP: _____

Referred By: _____ Insurance Carrier: _____Person responsible for this account: _____

What is your main complaint? : _____

_____

Other complaints: _____

How long have you had this condition? _____ Have you had this or a similar condition in the past? (Y) (N)

Is this condition getting progressively worse? (Y) (N) Constant (Y) (N) Comes and goes (Y) (N)

Is this condition interfering with your: Work (Y) (N) Sleep (Y) (N) Daily routine (Y) (N) other: _____

Are you on a statin Medication for Cholesterol? (Y) (N) if so, do you have any Body/Muscle Aches (Y) (N)

Who is your primary physician? _____

If you were involved in an accident, Please fill out below, otherwise continue to other side.

Auto Accident (Y) (N) Date: _____
Work Injury (Y) (N) Date: _____
Slip and fall (Y) (N) Date: _____

I was the:

Driver (Y) (N)
Front seat passenger (Y) (N)
Back seat passenger (Y) (N)
Pedestrian Crossing the road (Y) (N)
Riding a Bicycle (Y) (N)

The vehicle I was riding was hit from:

Behind-rear ended (Y) (N)
Drivers side (Y) (N)
Passenger's side (Y) (N)
Front collision (Y) (N)

Wearing seat belt (Y) (N)

Describe Accident: _____

_____

Did you go to the hospital? (Y) (N) If yes which hospital? _____ were X-Rays taken? (Y)(N)

If X-Rays were done, which of the following were taken? X-Rays of the: Neck (Y) (N) Lower Back (Y) (N) Ribs (Y) (N)

Other Be Specific: _____ Were you told if you had any broken bones or other abnormalities? (Y) (N)

If yes to above please specify: _____

Do you have an attorney? (Y) (N) 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 understand that if I suspend or terminate my care/treatment, any fees for personal services rendered to me will be immediately due And payable as well as any legal fees accrued due to delinquency.

Patient Signature: _____ Date: _____

All Patients Please fill out below:

At present time do you suffer from any of the following?

			0= No pain									10=Severe
Headaches:	(Y)	(N)	0	1	2	3	4	5	6	7	8	9	10
Neck Pain:	(Y)	(N)	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain:	(Y)	(N)	0	1	2	3	4	5	6	7	8	9	10
Mid-Back Pain:	(Y)	(N)	0	1	2	3	4	5	6	7	8	9	10

Neck Pain:	(Y) (N)	(R) (L)	(Bilateral)
Mid-back:	(Y) (N)	(R) (L)	(Bilateral)
Low Back:	(Y) (N)	(R) (L)	(Bilateral)

Do you suffer from any of the following? :

Radiation to the Arms/ Shoulders/ Hands:	(Y) (N)	Right	Left	Both
Radiation to the Legs/ Hips/ Feet:	(Y) (N)	Right	Left	Both
Numbness/ Tingling in the Arms/ Shoulders/ Hands:	(Y) (N)	Right	Left	Both
Numbness/ Tingling in Legs/Feet:	(Y) (N)	Right	Left	Both
Weakness/ Easy fatigue of the Arms/Legs:	(Y) (N)	Right	Left	Both
Weakness/ Easy fatigue of the Legs/Feet:	(Y) (N)	Right	Left	Both

If you suffer from headaches, where are they located?

Front of head ☐
Side of Head ☐
Back of head ☐

Do you experience any of the following with your headaches?

Lightheadedness/ Dizziness:	(Y) (N)	Sinus (allergy)	(Y) (N)
Sensation of Room Spinning:	(Y) (N)	Entire Head	(Y) (N)
Blurry Vision:	(Y) (N)	Back of Head	(Y) (N)
Ringing in Ears:	(Y) (N)	Forehead	(Y) (N)
Double Vision/ Floaters:	(Y) (N)	Temples	(Y) (N)
Nausea:	(Y) (N)	Migraine	(Y) (N)
Vomiting:	(Y) (N)	Head feels heavy	(Y) (N)
Loss of Consciousness:	(Y) (N)		
Seizures:	(Y) (N)		

Past Medical History:

High Blood Pressure	(Y) (N)
Diabetes	(Y) (N)
Heart Disease	(Y) (N)
Chest Pain	(Y) (N)
Neurological	(Y) (N)
Stomach/ Intestinal	(Y) (N)
Bleeding Disorder	(Y) (N)
Tuberculosis	(Y) (N)
Asthma	(Y) (N)
Thyroid	(Y) (N)
Cancer	(Y) (N)
Arthritis	(Y) (N)
Pacemaker	(Y) (N)
High Cholesterol	(Y) (N)

Any prior surgeries:_____
Allergies:_____
Medications: _____

General:

Nervousness	(Y) (N)
Irritable	(Y) (N)
Depression	(Y) (N)
Fatigue	(Y) (N)

Cigarettes _____daily/packs
Normal sleep_____ hours
Loss of weight _____lbs.
Gain of weight _____ lbs.
Coffee _____cups daily
Tea_____ cups daily
Exercise:_____