CASE HISTORY

Name ______________________________ Referred by _______________________ Date __________________

Address ____________________________ City _____________________ State _________ Zip ____________

Telephone ________________ Age _____ Birth date ____________ Sex ____ SS # ______________________

Occupation ____________________ Employer _________________________ Work Telephone ______________

Spouse's Name __________________ Occupation ____________________ Status: M S W D #. Children _______

Person responsible for this account ____________________ Email address _____________________________

What is your major complaint? ____

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Other complaints: ____

How long have you had this condition? __________ Have you had this or similar conditions in the past? ____________

If so, when? ___________ 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? ____

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 ____________________________ City: _______________ Diagnosis ___________________

Were X-rays taken? ________ What views? ____________________ Blood Tests _______ Other tests? __________

Treatments: Medications: ___________________________ Physical therapy: ____________________________

Results ______________________________________ Length of time under care ______________________

List surgical operations: ____

Were you off work? ________ If so, how long? _____________ Have you returned to your same job? _____________

If not, why? ____

ACCIDENT INFORMATION: *Please list any major accident including those in an automobile. Be sure to include all injuries*

Description of accident/injury: ____

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Were you unconscious? _______ Fractures ___________ Cuts _________ Abrasions _________ Bruises _________

Did your accident occur while at work? Yes ☐ No ☐ Were you involved in an auto accident? Yes ☐ No ☐

Date ____________ Time _______________ If injured at work was the injury reported to employer? Yes ☐ No ☐

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe ____

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:** ________________

Name____ **Date**________________________________

IMPORTANT: Please check (X) all present symptoms.

HEAD:

- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraines
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headed
- ☐ 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 (R – L)
- ☐ Pain in elbow (R – L)
- ☐ Movement aggravated
- ☐ Tennis elbow (R – L)
- ☐ Pain in forearm (R – L)
- ☐ Pain in hands (R – L)
- ☐ Pain in fingers (R – L)
- ☐ Pins & needles in arm (R – L)
- ☐ Pins & needles in fingers (R – L)
- ☐ Numbness in arms (R – L)
- ☐ Numbness in fingers (R – L)
- ☐ Fingers go to sleep (R – L)
- ☐ Hands cold (R – L)
- ☐ Swollen joints in fingers (R – L)
- ☐ Sore joints in fingers (R – L)
- ☐ Loss of grip strength

MID-BACK:

- ☐ Mid-Back Pan
- ☐ 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
  - ☐ Sacroiliac
- ☐ 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 (R – L)
- ☐ 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 (R – L)
- ☐ Outside (R – L)
- ☐ Leg cramps (R – L)
- ☐ Cramps in feet (R – L)
- ☐ Pins & Needles in legs (R –L)
- ☐ Numbness of leg (R – L)
- ☐ Numbness of feet (R – L)
- ☐ Numbness of toes (R – L)
- ☐ Feet feel cold (R – L)
- ☐ Swollen ankles (R – L)
- ☐ Swollen feet (R – L)

WOMEN ONLY:

- ☐ Menstrual Pain_______ (Where)
- ☐ Cramping
- ☐ Irregular cycles
- ☐ Cycle ________ days
- ☐ Birth control ___________ (type)
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Discharge
- ☐ Menopause **as of:** ____________
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:

- ☐ Urinary frequency
- ☐ Difficulty starting
- ☐ Night urination
- ☐ Prostate pains/swelling

GENERAL:

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep _________
- ☐ Loss of sleep ______ hrs./night
- ☐ Gain weight _______ lbs.
- ☐ Coffee ________ cups/day
- ☐ Cigarettes ________ packs/day
- ☐ Other symptoms:____________
- ☐ Diabetes
- ☐ Hypoglycemia

Your height: ____________________

Your current weight: ____________

REMARKS:

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