

# CASE HISTORY

Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Phone: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Driver's Lic. # \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: M / F  
Marital Status:  M  D  P  S  W  D # of Children: \_\_\_\_  
Person Responsible for this account: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employment Status:  Full Time  Part Time

Please list at least one contact person in case of emergency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is this condition either Employment related or Auto Accident related?  Yes  No If yes, please see front desk.

How were you referred to our Clinic?  Patient  Yellow Pages  Other Directory  Patient/Neighborhood Directory/Ads

Please name either the patient or specific source of your referral: \_\_\_\_\_

What is your major Complaint? (Pertaining to today's visit): \_\_\_\_\_

Other Complaints:

How long have you had this condition? \_\_\_\_\_

Have you had similar conditions in the past?  Yes  No Explain: \_\_\_\_\_

What aggravates your condition?  Walking  Sitting  Standing  Bending  Comes and Goes

Getting progressively worse?  Yes  No  Sleep  Work  Daily Routine  Other: \_\_\_\_\_

Is this condition interfering with your: \_\_\_\_\_

## OTHER DOCTORS SEEN FOR THIS CONDITION:

Doctor's Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Treatment: \_\_\_\_\_ X-ray (area): \_\_\_\_\_ Results: \_\_\_\_\_

Were you off work?  Yes  No If so, how long? \_\_\_\_\_ Have you returned to your same job?  Yes  No

Please list any surgeries: \_\_\_\_\_

Have you been diagnosed with a serious illness?  Yes  No If yes, explain: \_\_\_\_\_

Have you ever been in an auto accident?  Yes  No If yes, explain: \_\_\_\_\_

Have you ever been involved in any other accidents?  Yes  No If yes, explain: \_\_\_\_\_

Have you ever had any broken bones?  Yes  No If yes, explain: \_\_\_\_\_

Are you currently taking any medications and/or nutritional supplements/vitamins?  Yes  No If yes, explain: \_\_\_\_\_

By signing below: I understand and agree that the information I have provided is true to the best of my knowledge and that I am fin

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**IMPORTANT: General Health, please check (X) all symptoms**

**HEAD:**

- Headache
- Sinus (allergy)
- Entire head
- Back of head
- Migraine
- Temples
- Forehead
- Loss of memory
- Light headedness
- Loss of hearing
- Loss of taste
- Pain in ears
- Loss of balance or Dizziness

**NECK:**

- Turn to right
- Turn to left
- Bend to right
- Bend to left
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

**CHEST:**

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Irregular heartbeat

**ABDOMEN:**

- Nausea
- Gas
- Diarrhea
- Hemorrhoids
- Foods can't eat
- Nervous stomach
- \_\_\_\_\_

**LOW BACK:**

- Low back pain
- Upper lumbar
- Lower lumbar
- Sacroiliac
- Lifting pain is worse when: Bend, Sitting, Standing, Lifting, \_\_\_\_\_
- Slipped disc
- Muscle spasms
- Arthritis

**MID-BACK:**

- Mid-back pain
- Location: