

## CASE HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status  M  S  W  D No. of Children \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_  
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 this 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? \_\_\_\_\_  
List surgical operations \_\_\_\_\_  
\_\_\_\_\_

Are you taking any medications?  yes  no What kind? \_\_\_\_\_  
Any non-prescription drugs?  yes  no What kind? \_\_\_\_\_  
Other Doctor's seen for this condition  MD  DC  DO  DDS  
Doctor's Name \_\_\_\_\_ Diagnosis \_\_\_\_\_  
X-rays \_\_\_\_\_ Urinalysis \_\_\_\_\_ Blood Tests \_\_\_\_\_ Other \_\_\_\_\_  
Treatment: Medication \_\_\_\_\_ Physiotherapy \_\_\_\_\_  
Results \_\_\_\_\_ Length of time under care \_\_\_\_\_  
Were you off work?  yes  no If so, how long? \_\_\_\_\_ Have you returned to the same job?  yes  no  
If not, 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 insurance?  yes  no  
Insurance Company Name \_\_\_\_\_ Claim # \_\_\_\_\_ Group # \_\_\_\_\_  
Agent \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Additional Insurance Company \_\_\_\_\_ Claim # \_\_\_\_\_ Group # \_\_\_\_\_  
Agent \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Is your condition due to an  accident  illness  other \_\_\_\_\_  
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?  yes  no How? \_\_\_\_\_  
Location of injury \_\_\_\_\_  
Were you unconscious?  yes  no Fractures \_\_\_\_\_ Cuts \_\_\_\_\_ Abrasions \_\_\_\_\_ Bruises \_\_\_\_\_  
Patient taken to \_\_\_\_\_ Hospital for \_\_\_\_\_  
Confined to the hospital for \_\_\_\_\_ days \_\_\_\_\_ hours Name of hospital doctor \_\_\_\_\_  
Have you had any other personal injury or accident?  yes  no Please list when \_\_\_\_\_  
Do you have an attorney?  yes  no Attorney's 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. If I choose to suspend or terminate my care and treatment, any fees for professional services rendered to me are due immediately.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**Important:** Please check (x) all present symptoms.

**HEAD**

Headache:

- Sinus (allergy)
- Entire head
- Back of head
- Forehead
- Temples
- Migraine

General:

- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Eyes are light-sensitive
- 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**

Neck pain with movement:

- Forward
- Backward
- Turn to left
- Bend to left
- Turn to right
- Bend to right

General:

- Pain in neck
- Pinched nerve in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

**ARMS AND HANDS**

- Pain in upper arm
- Pain in elbow
- Movement aggravated
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins and needles (Arms-Fingers)
- Numbness in arms (R-L)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Arthritis in fingers
- Loss of grip strength

**SHOULDERS**

- Pain in shoulder joint (R-L)
- Pain across shoulders
- Bursitis (R-L)
- Arthritis (R-L)
- Tension in shoulders
- Pinched nerve in shoulder (R-L)
- Muscle spasms in shoulders
- Can't raise arm
  - Above shoulder level
  - Overhead

**BACK**

Mid Back:

- Mid-back pain
- 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
- Disc herniation
- Low back feels out of place
- Muscle spasms
- Arthritis

Low back pain is worse when:

- Working
- Lifting
- Stooping standing
- Sitting
- Bending
- Coughing
- Lying down (sleeping)
- Walking

Pain relieved when: \_\_\_\_\_

**CHEST**

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

**ABDOMEN**

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

**HIPS, LEGS AND FEET**

- Pain in buttocks
- Pain in hip joint
- Pain down leg (R-L)
- Pain down both legs
- Knee pain (R-L) (inside/outside)
- Leg cramps (R-L)
- Cramps in feet (R-L)
- Pins and needles in legs
- Numbness of legs (R-L)
- Numbness of toes (R-L)
- Feet feel cold
- Swollen ankles (R-L)
- Swollen feet (R-L)

**GENERAL**

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run down
- Normal sleep \_\_\_\_\_hrs/night
- Loss of sleep \_\_\_\_\_hrs/night
- Loss of weight \_\_\_\_\_lbs
- Gained weight \_\_\_\_\_lbs
- Coffee: \_\_\_\_\_ cups/day
- Tea: \_\_\_\_\_ cups/day
- Cigarettes: \_\_\_\_\_ pack/day
- Diabetes
- Hypoglycemia

**WOMEN ONLY**

- Cycle: \_\_\_\_\_ days
- Menstrual pain: where \_\_\_\_\_
- Cramping
- Irregularity
- Birth control: type \_\_\_\_\_
- Hysterectomy
- Genital cancer
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you are pregnant?

**MEN ONLY**

- Prostate pain/swelling
- Urinary frequency \_\_\_\_\_
- Difficulty in starting
- Night urination

**REMARKS** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient's signature