

## CASE HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Social Security # \_\_\_\_\_ Drivers Lic. # \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status M DP S W D # of Children \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_  
Spouse or Partner'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 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? \_\_\_\_\_

List surgical operations: \_\_\_\_\_

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 \_\_\_\_\_ Diagnosis \_\_\_\_\_

X-rays \_\_\_\_\_ Urinalysis \_\_\_\_\_ Blood Tests \_\_\_\_\_ Other \_\_\_\_\_

### 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

Name of Insurance Company \_\_\_\_\_ Claim # \_\_\_\_\_ Group # \_\_\_\_\_ Agent \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Additional Insurance Company \_\_\_\_\_ Claim # \_\_\_\_\_ Group # \_\_\_\_\_ Agent \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Is your condition due to an accident?  YES  NO  Illness  Other \_\_\_\_\_

Did accident occur while at work?  YES  NO Were you involved in an automobile accident?  YES  NO

Date \_\_\_\_\_ Time \_\_\_\_\_ Injury reported to employer? \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Description of accident \_\_\_\_\_

Were you injured? \_\_\_\_\_ How? \_\_\_\_\_

Location \_\_\_\_\_

Were you unconscious? \_\_\_\_\_ Fractures \_\_\_\_\_ Cuts \_\_\_\_\_ Abrasions \_\_\_\_\_ Bruises \_\_\_\_\_

Patient taken to \_\_\_\_\_ Hospital for \_\_\_\_\_

Confined to hospital for \_\_\_\_\_ days \_\_\_\_\_ hours. Name of hospital doctor \_\_\_\_\_

Have you had any other personal injury or accident?  Past Year  Past 5 Years  Over 5 Years  None

Do you have an attorney?  YES  NO 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 and treatment, any fees for services rendered to me will be immediately due and payable.

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

\_\_\_\_\_  
Date

**IMPORTANT:** Please check (X) all present symptoms.

**HEAD:**

**Headache**

- sinus (allergy)
- entire head
- back of head
- forehead
- temples
- migraine
- Head feels heavy
- Loss of memory
- Light-Headedness
- Fainting
- Light bother 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

**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 in arms
- Sensation of pins and needles in fingers
- Numbness in arms (R-L)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore 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)
- Can't raise arm
  - above shoulder level
  - over head
- Tension in shoulders
- Pinched nerve in shoulder ( R- L )
- Muscle spasms in shoulders

**MID BACK:**

- Mid-back pain
- 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 relieved when \_\_\_\_\_
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

**HIP, LEGS, AND FEET:**

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

**WOMEN ONLY:**

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

**MEN ONLY:**

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

**GENERAL**

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep \_\_\_\_\_ hrs/night
- Loss of sleep \_\_\_\_\_ hrs/night
- Loss of weight \_\_\_\_\_ lbs
- Gain weight \_\_\_\_\_ lbs
- Coffee \_\_\_\_\_ cups/day
- Tea \_\_\_\_\_ cups/day
- Cigarettes \_\_\_\_\_ pack/day
- Other \_\_\_\_\_
- Diabetes
- Hypoglycemia

**REMARKS:**

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

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