# Patient Case History

**HIPAA**
**Protected Health Information**
**Authorized Access Only**

CONFIDENTIAL

Date _____ Case # _____

Patient/Clinic I.D. # _____ Driver's License # _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Insurance Co. _____ Insurance Phone _____

Sex ❑ M ❑ F Age ___ Date of Birth _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Occupation _____ Shift 1 2 3 Description _____

Employer _____ Work Phone _____ Ext. _____

Work Address _____ Years Worked _____

Spouse _____ List Children _____

Spouse's Social Security _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone _____ Ext. _____

Spouse's Insurance _____ Spouse's Insurance Phone _____

Last Doctor's Name _____ List Medications _____

Care Received _____ List Surgeries _____

Results _____

Are your present problems due to an injury? ❑ Yes ❑ No ❑ On the Job ❑ Auto Collision ❑ Personal Injury ❑ Other

Have you made a report of your accident? ❑ Yes ❑ No ❑ To Employer ❑ Auto Carrier ❑ Other _____

Has the accident been reported? ❑ Yes ❑ No ❑ Workers' Comp ❑ Auto Carrier ❑ Other _____

Are you now or have you ever been disabled/impaired? (Service or Work?) ❑ Yes ❑ No When _____

Have you retained an attorney? ❑ Yes ❑ No Name & Address _____

## CHIEF COMPLAINT / REGIONS OF PAIN

1) _____
2) _____
3) _____
4) _____

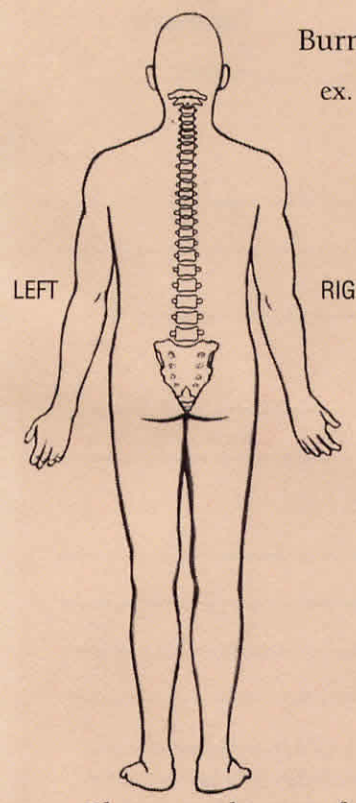
## SEVERITY OF PAIN

List region of pain and circle severity number. (1 = least, 10 = greatest)

ex. Neck _____ *sharp*
1 2 3 4 5 6 7 (8) 9 10

## MARK PAIN REGION

Burning • Stabbing • Sharp • Constant




## MARK PAIN AREA

| | |
|---|---|
| +++ | Burning |
| 000 | Stabbing |
| --- | Sharp |
| III | Constant |
| XXX | Other |

## REGIONS

Neck _____
1 2 3 4 5 6 7 8 9 10

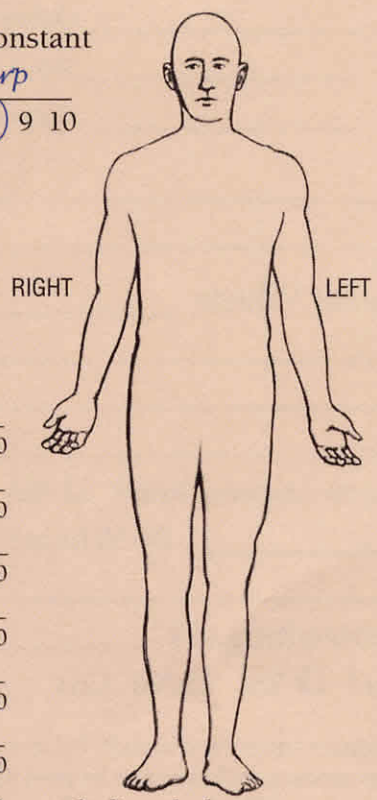
Mid Back _____
1 2 3 4 5 6 7 8 9 10

Low Back _____
1 2 3 4 5 6 7 8 9 10

Hips _____
1 2 3 4 5 6 7 8 9 10

Arms _____
1 2 3 4 5 6 7 8 9 10

Legs _____
1 2 3 4 5 6 7 8 9 10




Please mark area of pain on the drawing using the code listed above.

## HABITS

| | | |
|---|---|---|
| ❑ Smoking | Packs/Day | _____ |
| ❑ Alcohol | Cups/Day | _____ |
| ❑ Coffee | Cups/Day | _____ |
| ❑ Soda Pop | Cups/Day | _____ |

## EXERCISE

❑ None
❑ Moderate
❑ Daily
Type _____

## HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

| | | |
|---|---|---|
| ❑ 303.9 Alcoholism | ❑ 345. Epilepsy | ❑ 072. Mumps |
| ❑ 280. Anemia | ❑ 240. Goiter | ❑ 511. Pleurisy |
| ❑ 541. Appendicitis | ❑ 429.9 Heart Disease | ❑ 480. Pneumonia |
| ❑ 716. Arthritis | ❑ 042. HIV Positive | ❑ 045. Polio |
| ❑ 239. Cancer | ❑ 487. Influenza | ❑ 390. Rheumatic Fever |
| ❑ 052. Chicken Pox | ❑ 724.2 Low Back Pain | ❑ 737.30 Scoliosis |
| ❑ 250. Diabetes | ❑ 055. Measles | ❑ 846. Sprain/Strain Sacroiliac |
| ❑ 690. Eczema | ❑ 319. Mental Disorder | ❑ 847.0 Whiplash |

## FAMILY HISTORY

| | | Diabetes | Heart | Kidney | Cancer | Back |
|---|---|---|---|---|---|---|
| Mother – Living | Y ❑ N ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Father – Living | Y ❑ N ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Brother(s), # of ____ | | ❑ | ❑ | ❑ | ❑ | ❑ |
| Sister(s), # of ____ | | ❑ | ❑ | ❑ | ❑ | ❑ |
| Adoption History | | ❑ | ❑ | ❑ | ❑ | ❑ |

## OFFICE USE ONLY

Patient's Last Physical _____
Patient's Last Lab _____
Patient's Last X-ray _____
Patient's Prostate Exam _____
Patient's Last Pap Smear _____
Patient's Last Breast Exam _____

Patient's Last Spinal Exam _____
Patient's Last Spinal X-ray _____
Patient's Last EMG _____
Patient's Last Infrared Thermography _____
Patient's Last Disc Exam _____
Patient's Last MRI _____ CT Scan _____
Notes _____

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable.
A complete history and understanding of your health will facilitate care.

### GENERAL SYMPTOMS

____ 784.0 Headache
____ 780.6 Fever
____ 780.99 Chills
____ 780.8 Night Sweats
____ 780.2 Fainting
____ 780.4 Dizziness
____ 780.3 Convulsions
____ 780.52 Loss of Sleep
____ 780.7 Fatigue
____ 799.2 Nervousness
____ 783. Loss of Weight
____ 782. Numbness or pain in arms/legs/hands
____ 995.3 Allergy (What)
____ 786.07 Wheezing
____ 729.2 Neuralgia

### MUSCLES & JOINTS

____ 728.9 Weakness
____ 781.0 Twitching
____ 723.5 Stiff Neck
____ 724.5 Backache
____ 719.0 Swollen Joints
____ 781. Tremors
____ 729.5 Foot Trouble
____ 724.79 Painful Tail Bone
____ 724.5 Pain Between Shoulders
____ 737.3 Spinal Curvature

### GASTRO-INTESTINAL

____ 783. Poor Appetite
____ 536.8 Poor Digestion
____ 994.2 Starvation
____ 787.3 Belching or Gas
____ 787.0 Nausea
____ 787.0 Vomiting
____ 578.0 Vomiting Blood
____ 536.8 Pain over Stomach
____ 564.0 Constipation
____ 787.91 Diarrhea
____ 562.1 Colon Trouble
____ 455.6 Hemorrhoids (Piles)
____ 776.7 Fluid Retention
____ 873.9 Liver Trouble
____ 274. Gout
____ 782.4 Jaundice
____ 575.9 Gall Bladder Trouble

### CARDIO–VASCULAR

____ 785.0 Rapid Heart
____ 427.89 Slow Heart
____ 401.9 High Blood Pressure
____ 458.9 Low Blood Pressure
____ 786.51 Pain Over Heart
____ 429.9 Heart Trouble
____ 719.07 Swelling Ankles
____ 459.9 Poor Circulation
____ 454.9 Varicose Veins
____ 436. Strokes
____ 785.1 Palpitations

### EYE/EAR/NOSE/THROAT

____ 368.9 Poor Vision
____ 378.0 Crossed Eyes
____ 379.91 Pain in Eyes
____ 389.9 Deafness
____ 388.70 Earache
____ 388.30 Ear Noises
____ 388.60 Ear Discharges
____ 478.1 Nasal Obstruction
____ 784.7 Nose Bleeds
____ 462. Sore Throats
____ 784.49 Hoarseness
____ 477.9 Hay Fever
____ 493.9 Asthma
____ 460. Frequent Colds
____ 240.9 Enlarged Thyroid
____ 463. Tonsillitis
____ 473. Sinus Trouble

### SKIN OR ALLERGIES

____ 680. Skin Eruptions – No
____ 698.9 Itching
____ 924.9 Bruising Easily
____ 701.1 Dryness
____ 680.9 Boils
____ 782. Sensitive Skin
____ 708.9 Hives or Allergy
____ 692.9 Eczema
____ Medicines

_____
_____
_____

### RESPIRATORY

____ 786.2 Chronic Cough
____ 786.3 Spitting Blood
____ 786.4 Spitting Phlegm
____ 786.50 Chest Pain
____ 786.09 Difficulty Breathing

### GENITO-URINARY

____ 788.4 Frequent Urination
____ 788.1 Painful Urination
____ 599.7 Blood in Urine
____ 590. Kidney Infection
____ 788.3 Bed Wetting
____ 788.3 Inability to control Urine
____ 601.9 Prostate Trouble

### FOR WOMEN ONLY

____ 625.3 Painful Periods
____ 626.2 Excessive Flow
____ 626.4 Irregular Cycle
____ 627.2 Hot Flashes
____ 625.3 Cramps or Backaches
____ 623.5 Vaginal Discharge
____ Pregnant at this Time
____ Last Pap

By Whom _____
Other _____

## IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES – HOSPITALIZATION

| DATE | | DATE | | DATE | | DATE | |
|---|---|---|---|---|---|---|---|
| _____ | Vaccinations | _____ | Other | _____ | Rectal Surgery | _____ | Thyroid |
| _____ | Tonsillectomy | _____ | Tubes in Ears | _____ | Other | _____ | Stomach |
| _____ | Gall Bladder | _____ | Appendectomy | _____ | Sinus | _____ | Other |
| _____ | Back Operation | _____ | Female Organs | _____ | Hernia | | |

Hospital Stays _____
Other Surgeries _____

List any accidents or falls/list dates: ❑ Car _____ ❑ Recreational Vehicle _____ ❑ Sports _____
❑ School _____ ❑ Other _____

List any broken bones (fractures) or dislocations: _____
Have you ever been on crutches? ❑ Yes ❑ No Why? _____
Have you ever had a lapse of memory? ❑ Yes ❑ No Have you ever been unconscious? ❑ Yes ❑ No
Have you ever had X-rays taken? ❑ Yes ❑ No When? _____ By Whom? _____
For what ailments were these X-rays made? _____
Do you suffer from any condition other than that for which you are now consulting us? _____
Are you presently taking any medication - prescription or over-the-counter? ❑ Yes ❑ No List: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file and x-rays upon request. Copying fees may apply.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Doctor Signature _____ Date _____