CASE HISTORY

Name_____ Social Security # _____/_____/_____ Date_____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____ E-Mail _____
Driver Lic. # _____ Age _____ Birthdate _____ Sex: Male Female
Marital Status: Married Single Widowed Divorced Number of Children _____
Occupation _____ Employer _____ Years Employed _____
Employer's Address _____ City _____ State _____ Zip _____
Spouse's Name _____ Occupation _____ Employer _____
Person responsible for this account _____ Referred by _____
What is your major complaint? _____
_____
_____
Other complaints: _____
_____
What caused your condition? _____
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 ☐ COME 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 & strength? _____
_____
Any non-prescription drugs? _____ What kind?_____
Name of Family Physician _____ Date Last Seen _____

OTHER DOCTORS SEEN FOR THIS CONDITION: MD ☐ DC ☐ DO ☐ DDS ☐
Doctor's Name _____ Dates Treated _____
Doctor's Name _____ Dates Treated _____
Doctor's Name _____ Dates Treated _____
Diagnosis _____
X-rays & Dates _____ Medication _____
MRI(date & body region) _____
Physical Therapy Dates _____
Treatment Results _____ Length of time under care _____
Other Tests & Dates _____

ACCIDENT INFORMATION:
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 _____

I clearly understand and agree that all services rendered to me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered to me will be immediately due & payable.

Patient Signature _____ Date _____

Name:___________________________ **Date:**___________________________

HEAD

- ☐ Headache
  - ☐ Sinus (allergy)
  - ☐ Entire Head
  - ☐ Back of Head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ 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
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis Elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R- L)
- ☐ Numbness in fingers (R- L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

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

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 disc
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ 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
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R- L)
- ☐ Pins & needles in legs (R- L)
- ☐ Numbness of leg (R- L)
- ☐ Numbness of feet (R- L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R- L)
- ☐ Swollen feet (R- L)

REMARKS:

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Name:_____**Date:**_____

REVIEW OF SYSTEMS – Check only the ones you now **have** or have **had** in the past.

General	**Now**	**Past**
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐

Skin	**Now**	**Past**
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐

Head	**Now**	**Past**
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐

Ears	**Now**	**Past**
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐

Nose	**Now**	**Past**
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐

Mouth	**Now**	**Past**
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

Throat	**Now**	**Past**
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Throat Infections	☐	☐

Neck	**Now**	**Past**
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐

Breasts	**Now**	**Past**
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐

Lungs	**Now**	**Past**
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐

Heart	**Now**	**Past**
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain	☐	☐
Chest Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐

Blood	**Now**	**Past**
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

Gastrointestinal	**Now**	**Past**
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐

Genitourinary	**Now**	**Past**
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐

Genitourinary	**Now**	**Past**
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting w/ Periods	☐	☐
Menstrual Cramps	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐
Contraception Type	_____	
Age at First Period	_____	
Duration of Cycle	_____	
Duration of Flow	_____	
No. of Pregnancies	_____	
No. of Miscarriages	_____	
No. of Abortions	_____	
Menstrual Flow	☐Heavy ☐Mod ☐Light	
Last Period	_____	
Last Pap Smear	_____	
Last Vaginal Exam	_____	
Last Mammogram	_____	
Last Prostate Exam	_____	

Neurologic	**Now**	**Past**
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Speech Difficulty	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

Endocrine	**Now**	**Past**
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

Psychiatric	**Now**	**Past**
Hyperventillation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

Name:_____ **Date:**_____

Musculoskeletal	**Now**	**Past**
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

Immunization/Vaccinations

DPT	☐
Mumps	☐
Smallpox	☐
Thyroid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

Blood Type

A+	☐	A-	☐
B+	☐	B-	☐
AB+	☐	AB-	☐
O+	☐	O-	☐

Surgeries

Date_____ Type _____
Date_____ Type _____
Date_____ Type _____
Date_____ Type _____

Social History

Current Weight _____
Have you recently gained _____ or lost _____ weight? How much? _____

Mental Work

☐ Heavy ☐Mod ☐ Light
Hours Per Day _____

Physical Work

☐ Heavy ☐Mod ☐ Light
Hours Per Day _____

Exercise

☐ Heavy ☐Mod ☐ Light
Hours Per Week_____
Type of Exercise _____

Smoking

☐ Current ☐Previous
Packs Per Day _____
Smoked for how long? _____

Caffeine

Coffee _____ Tea _____ Soda ____
Cups/Day _____ No. of Years _____

Alcohol

Beer/week _____ Wine/week _____
Liquor/week _____ No. of Years ___

Aspirin

No./Day _____ No. of Years _____

Family History

Check any of the diseases that have occurred within your family.
☐ Heart Disease ☐ Heart Attack
☐ Stroke ☐ Emphysema
☐ Diabetes ☐ Cancer

PAST MEDICAL HISTORY – Check only the ones you have had in the past.

Hay Fever	☐	Epilepsy	☐
Mumps	☐	Paralysis	☐
Rheumatic Fever	☐	Polio	☐
Allergies	☐	Mental Illness	☐
Cancer	☐	Alcoholism	☐
Tumor	☐	Depression	☐
Blood Disease	☐	Nervous Breakdown	☐
Leukemia	☐	Migraine	☐
Heart Trouble	☐	Gout	☐
Varicose Veins	☐	Hemorrhoids	☐
Phlebitis	☐	Prostate Problems	☐
Hypertension	☐	Sexual Problems	☐
Stroke	☐	Gonorrhea	☐
Ulcers	☐	Syphilis	☐
Jaundice	☐	Diabetes	☐
Skin Trouble	☐	Bladder Trouble	☐
Liver Trouble	☐	Kidney Stones	☐
Angina	☐	Dysentery	☐
Hepatitis	☐	Parasites	☐

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal
Last TB Skin Test _____ ☐ Normal ☐ Abnormal
Allergies: _____

Mark An "X" On The Lines:
How bad are your symptoms now? _____
Mild Moderate Severe
How bad have they been in the past? _____
Mild Moderate Severe
Mark The Areas Of Your Symptoms On The Figure Below:
Use the following symbols:

Aches ^^^^^ ^^^^^ **Numbness** ooooo **ooooo** **Pins/Needles** .... **Stabbing** ///// /////