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? ____

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____

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 Med & 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: ______________________

HEAD

- ☐ Headache
  - ☐ Sinus (allergy)
  - ☐ Entire Head
  - ☐ Back of Head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
  - ☐ Head feels heavy
  - ☐ Loss of memory
- ☐ Lightheadedness
  - ☐ 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 aim
- ☐ 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

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 v
- ☐ 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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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		

BREAST		
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		
Discharge		
Impotence		
Dribbling		
Cloudy Urine		

Urine Color: ___________________________________

Spotting w/ Periods		
Menstrual Cramps		
Itching		
Painful Intercourse		
Irregular Periods		

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 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	PAST	NOW
Hyperventilation		
Insecurity		
Depression		
Troubled Sleep		
Irritable		
Undecidedness		
Timid		
Hallucinations		
Loss of Memory		
Alcoholism		
Drug Addiction		
Suicidal Thoughts		
Extreme worry		
Sexual problems		

MUSCULOSKELETAL	**NOW**	**PAST**
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐
IMMUNIZATION	**NOW**	**PAST**
DPT	☐	☐
Mumps	☐	☐
Smallpox	☐	☐
Thyroid	☐	☐
Tetanus	☐	☐
Measles	☐	☐
Pneumococcal	**NOW**	**PAST**
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________________

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/ day_____ No. of years ____

ASPIRIN

No. / day_____ No. of years ____

FAMILY HISTORY

☐ 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	☐

Date of last chest X-Ray Normal Abnormal

Last TB Skin Test Normal Abnormal

Allergies ____

Mark an "X" on the lines:

How bad your symptoms are now? ________________________________

Mild Severe Moderate

How bad have they been in the past? ________________________________

Mild Severe Moderate

Mark the areas of your symptoms on the figure below

Use the following symptoms:

Aches ^^^^^ Numbness ooooo Pins and needles ……… Stabbing /////

^^^^^ ooooo ……… /////