CASE HISTORY

Name: ________________________________ Social Security # ______ /______ /______ Date: _______________
Address: ________________________________ City: ____________ State: _____________ Zip: _____________
Home # ___________________________ Work# ___________________ Ceil# ______________ E-Mail: ____________
Driver Lic. # ___________________________ Age: _____ Birthdate: ________________ Sex: Male Female
Mantel 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 Mad & 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	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	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐

Urine Color: ___________________________________

	NOW	PAST
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 ooooo Pins and needles ……… ……… Stabbing ///// /////