

Further Chiropractic Case History

First Name: _____ Last Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Social Security #: _____ Driver's License # _____

Date of Birth: _____ Age: _____ Sex: _____

Marital Status : Married Single Widowed Divorced # of Children: _____

Occupation: _____ Employer: _____

of Years Employed: _____ Employer's Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Spouse'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 & goes

Is this condition interfering with: Work Sleep Daily Routine Other: _____

How long has it been since you felt really good? _____

List Surgical operations: _____

OTHER DOCTORS SEEN FOR THIS CONDITION? (Circle): MD DC DO DDS

Doctor's Name: _____ Diagnosis: _____

X-rays: _____ Urinalysis: _____ Blood Tests: _____ Other: _____

Treatment: Medication: _____ Physiotherapy: _____

INSURANCE INFORMATION:

Are you covered by Medicare?: Yes No Medicare #: _____ State Insurance Aid?: Yes No

Do you have any group, union or personal health and accident insurance?: Yes No

Name of Insurance Company: _____ Claim #: _____ Group #: _____

Address: _____ Phone: _____ Agent: _____

Additional Insurance Company: _____ Claim #: _____ Group #: _____

Address: _____ Phone: _____ Agent: _____

Is your condition due to an accident?: Illness? Other: _____

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ACCIDENT INFORMATION

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: _____

Description of Accident: _____

Were you injured?: _____ How?: _____

Location: _____

Were you unconscious?: _____ Fractures?: _____ Cuts?: _____

Abrasions?: _____ Bruises? _____

Patient taken to: _____ Hospital for: _____ Treatment

Confined to hospital for: _____ Days _____ Hours Name of Hospital doctor: _____

Have you had any personal injury or accident?: Past Year Past 5 years Over5 years None

Describe: _____

Do you have an attorney?: Yes No Name & 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 professional services rendered to me will be immediately due and payable.

Patients Signature: _____ Date: _____

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IMPORTANT: Please check (x) all present symptoms

<p>HEAD:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headache <ul style="list-style-type: none"> <input type="checkbox"/> sinus (allergy) <input type="checkbox"/> entire head <input type="checkbox"/> back of the head <input type="checkbox"/> forehead <input type="checkbox"/> temples <input type="checkbox"/> migraine <input type="checkbox"/> Head feels heavy <input type="checkbox"/> Loss of memory <input type="checkbox"/> Light-headedness <input type="checkbox"/> Faintness <input type="checkbox"/> Light bothers eyes <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Loss of vision <input type="checkbox"/> Loss of taste <input type="checkbox"/> Loss of balance <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Pain in ears <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Buzzing in ears <p>NECK:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck with movement <ul style="list-style-type: none"> <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turn to left <input type="checkbox"/> Turn to right <input type="checkbox"/> Bend to left <input type="checkbox"/> Bend to right <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck <input type="checkbox"/> Grinding sounds in neck <input type="checkbox"/> Popping sounds in neck <input type="checkbox"/> Arthritis in neck 	<p>SHOULDERS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in shoulder joint (R – L) <input type="checkbox"/> Pain across shoulders <input type="checkbox"/> Bursitis (R – L) <input type="checkbox"/> Arthritis (R – L) <input type="checkbox"/> Can't raise arm <ul style="list-style-type: none"> <input type="checkbox"/> above shoulder level <input type="checkbox"/> over head <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Pinched nerve in shoulder (R – L) <input type="checkbox"/> Muscle spasms in shoulder <p>ARMS & HANDS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in upper arms <input type="checkbox"/> Pain in elbow <input type="checkbox"/> Movement aggravated <input type="checkbox"/> Tennis Elbow <input type="checkbox"/> Pain forearm <input type="checkbox"/> Pain in hands <input type="checkbox"/> Pain in fingers <input type="checkbox"/> Sensation of pins & needles in arms <input type="checkbox"/> Sensation of pins & needles in fingers <input type="checkbox"/> Numbness in arms (R – L) <input type="checkbox"/> Numbness in fingers (R – L) <input type="checkbox"/> Fingers go to sleep <input type="checkbox"/> Hands cold <input type="checkbox"/> Swollen joints in fingers <input type="checkbox"/> Sore joints in fingers <input type="checkbox"/> Arthritis in fingers <input type="checkbox"/> Loss of grip/strength <p>MID-BACK:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mid-Back pain <input type="checkbox"/> Location: _____ <input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Sharp stabbing <input type="checkbox"/> Dull ache <input type="checkbox"/> Pain from front to back <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Pain in kidney area 	<p>CHEST:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Pain around ribs <input type="checkbox"/> Breast pain <input type="checkbox"/> Dimpled or orange peel breasts <input type="checkbox"/> Irregular heartbeat <p>ABDOMEN:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervous stomach <input type="checkbox"/> Foods can't eat: _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <p>LOW BACK:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Low Back Pain <ul style="list-style-type: none"> <input type="checkbox"/> Upper Lumbar <input type="checkbox"/> Lower Lumbar <input type="checkbox"/> Sacroiliac <input type="checkbox"/> Low back pain is worse when: <ul style="list-style-type: none"> <input type="checkbox"/> working <input type="checkbox"/> lifting <input type="checkbox"/> stooping <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> bending <input type="checkbox"/> coughing <input type="checkbox"/> lying down (sleeping) <input type="checkbox"/> walking <input type="checkbox"/> Pain relieves when: _____ <input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Arthritis
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<p>HIPS, LEGS & FEET:</p> <p><input type="checkbox"/> Pain in buttocks (R – L)</p> <p><input type="checkbox"/> Pain in hip joint (R – L)</p> <p><input type="checkbox"/> Pain down leg (R – L)</p> <p><input type="checkbox"/> Pain down both legs</p> <p><input type="checkbox"/> Knee pain</p> <p style="padding-left: 20px;"><input type="checkbox"/> Inside</p> <p style="padding-left: 20px;"><input type="checkbox"/> Outside</p> <p><input type="checkbox"/> Leg cramps</p> <p><input type="checkbox"/> Cramps in feet (R – L)</p> <p><input type="checkbox"/> Pins & Needles in leg (R – L)</p> <p><input type="checkbox"/> Numbness in legs (R – L)</p> <p><input type="checkbox"/> Numbness in feet (R – L)</p> <p><input type="checkbox"/> Numbness of toes</p> <p><input type="checkbox"/> Feet feel cold</p> <p><input type="checkbox"/> Swollen ankles</p> <p><input type="checkbox"/> Swollen feet (R – L)</p> <p>WOMEN ONLY:</p> <p><input type="checkbox"/> Menstrual pain: _____ _____ (where)</p> <p><input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Irregularity</p> <p><input type="checkbox"/> Cycle _____ Days</p> <p><input type="checkbox"/> Birth control _____ _____ (type)</p> <p><input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> Genital cancer</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> Tumours</p> <p><input type="checkbox"/> Abortions _____</p> <p>_____</p> <p><input type="checkbox"/> Are you or do you think you are pregnant?</p>	<p>MEN ONLY:</p> <p><input type="checkbox"/> Urinary frequency</p> <p><input type="checkbox"/> Difficulty in starting</p> <p><input type="checkbox"/> Night urination</p> <p><input type="checkbox"/> Prostate pain/swelling</p> <p>GENERAL:</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Irritable</p> <p><input type="checkbox"/> Depressed</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> General feel run-down</p> <p><input type="checkbox"/> Normal sleep _____</p> <p><input type="checkbox"/> Loss of sleep _____ hours/night</p> <p><input type="checkbox"/> Loss of weight _____ lbs</p> <p><input type="checkbox"/> Gain of weight _____ lbs</p> <p><input type="checkbox"/> Coffee _____ cups/day</p> <p><input type="checkbox"/> Tea _____ cups/day</p> <p><input type="checkbox"/> Cigarettes _____ pack/day</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Hyperglycemia</p>	<p>REMARKS:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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Please complete this form and fax or email to:
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