

# PATIENT CASE HISTORY

Date \_\_\_\_\_ Case # \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Are your present problems due to an injury?  No  Yes  On the Job  Personal Injury  Other \_\_\_\_\_  
 Auto Collision – Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Have you made a report of your accident?  No  Yes  Employer  Auto Insurance  Other \_\_\_\_\_

Are you now or have you ever been disabled/impaired?  No  Yes When? \_\_\_\_\_

Have you retained an attorney?  No  Yes Name, & Phone \_\_\_\_\_

Have you ever seen a Chiropractor before?  No  Yes If so, whom and when? \_\_\_\_\_

Do you smoke?  No  Yes – Packs per day \_\_\_\_\_ Do you drink alcohol?  No  Yes - Amount \_\_\_\_\_

## HISTORY

Have you had any of the following conditions?

- |                                      |   |   |  |                                       |
|--------------------------------------|---|---|--|---------------------------------------|
| <input type="checkbox"/> Alcoholism  | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Cancer       |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Depression               | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Epilepsy     |
| <input type="checkbox"/> Fainting    | <input type="checkbox"/> Goiter                   | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Influenza   | <input type="checkbox"/> Low Back Pain            | <input type="checkbox"/> Measles          | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Pleurisy     |
| <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Polio                    | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Rheumatic Fever     |                                       |
| <input type="checkbox"/> Scoliosis   | <input type="checkbox"/> Sprain/Strain Sacroiliac | <input type="checkbox"/> Whiplash         |  |                                       |

## FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back Pain
Mother – Living <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father – Living <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## PAIN

What is the exact area of pain? \_\_\_\_\_

Please check all that apply:

- Sharp/Stabbing  Dull  Numbness  Burning  Throbbing  Soreness  
 Achey  Tingling  Weakness  Shooting Pains  Tense/Tightness

Does the pain radiate to other regions? \_\_\_\_\_

When did this symptom begin? \_\_\_\_\_

Since this symptom began, is the pain:  Improving  Getting Worse  Improves, then gets worse again  No Change

What gives relief?  Walking  Standing  Lying Down  Movement  Sitting  Exercise  Rest  Other \_\_\_\_\_

How often is this symptom present?  Constantly  Frequently  Intermittently  Occasionally

How intense is this symptom?  Severe  Moderate  Slight

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_