PATIENT CASE HISTORY

Today's date:					PCP:	
PATIENT INFORMATION						
Patient's last name: First: Middle:			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Wid	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security no.:		Age:	Sex:: ☐M ☐F	Birthdate:: / /
Street address:			Cell phone no: ( )		Home phone no.: ( )	
City:	State:	Zip Code:	May we contact you by email? Email address:			
Occupation:	Employer:				Work phone no.: ( )	
Referred by: (name)			Dr.			

What is your major complaint?

Other complaints:

How long have you had this condition? _____ Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Intermittent

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other (please describe)

List surgical operations:

List any prescribed medications you are currently taking:

List any nonprescription medications you are currently taking:

Do you have any medical conditions we should be aware of?

Is your condition related to: ☐ Work ☐ Auto ☐ Other (please describe)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary Insurance:	Subscriber's name:		Subscribers ID	Birth date:
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other
Name of secondary Insurance:	Subscriber's name:		Subscribers ID	Birth date:
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Have you been treated by a physical/occupational therapist this year? ☐ No ☐ Yes (last seen & number of visits)_____

Have you been treated by a chiropractor this year? ☐ No ☐ Yes (last seen & number of visits)_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell/Work phone no.: ( )

The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*

Please check all present symptoms

HEAD:
- ☐ Headache
  - ☐ Sinus (allergy)
  - ☐ Entire head
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light headed
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ear
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to right
  - ☐ Bend to left
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasm in neck
- ☐ Grinding sound in neck
- ☐ Popping sound in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulders (R or L)
- ☐ Pain across shoulders
- ☐ Bursitis (R or L)
- ☐ Arthritis (R or L)
- ☐ Can't raise arm ((R or L)
  - ☐ Above shoulder level
  - ☐ Over head
- ☐ tension in shoulders
- ☐ Pinched nerve in shoulders
- ☐ Muscle spasms in shoulders (R or L)

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
- ☐ In fingers
- ☐ Numbness in arms (R or L)
- ☐ In fingers (R or L)
- ☐ Fingers go to sleep (R or L)
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Location
- ☐ Pain between shoulders
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrholds

LOW BACK:
- ☐ Upper lumbar
- ☐ Lower
- ☐ Sacroiliac
- ☐ Low back pain in worse when
- ☐ Worked
- ☐ Lifting
- ☐ Stooping
- ☐ Standing
- ☐ Bending
- ☐ Coughing
- ☐ Lying down (sleeping)
- ☐ Walking
- ☐ Pain relievers when
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R or L)
- ☐ Pain in Hip joint (R or L)
- ☐ Pain down leg(R or L)
- ☐ Pain in both legs
- ☐ Knee pain(R or L)
- ☐ Inside
- ☐ Outside
- ☐ Leg cramps (R or L)
- ☐ Cramps in feet (R or L)
- ☐ Pins & needles in legs (R or L)
- ☐ Numbness in legs (R or L)
- ☐ Numbness in Feet
- ☐ Numbness in Toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R or L)
- ☐ Swollen feet (R or L)

WOMEN ONLY:
- ☐ Menstrual pain_____when
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle_____days
- ☐ Birth control
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Discharge
- ☐ Menopause
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urinating
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritability
- ☐ Depression
- ☐ Fatigue
- ☐ Generality feel rundown
- ☐ Normal sleep_____ hrs. P/night
- ☐ Loss of sleep___ hrs. P/night
- ☐ Loss of weight____ lbs.
- ☐ Gain weight_____lbs.
- ☐ Coffee _____cups p/day
- ☐ Tea _____cups p/day
- ☐ Cigarettes_____ packs p/day
- ☐ Other
- ☐ Diabetes
- ☐ Hypoglycemia

REMARKS:

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