

CONFIDENTIAL PATIENT CASE HISTORY

Today's Date

NAME: _____ SOCIAL SECURITY #: _____ - _____ - _____

ADDRESS: _____ DATE OF BIRTH: _____ / _____ / _____ AGE

SUITE / APT: _____ OCCUPATION: _____

CITY: _____ EMPLOYER: _____

STATE: _____ ZIP: _____ MARRIED / SINGLE: Spouse's Name? _____

PHONE HOME / CELL : _____ EMERGENCY CONTACT: _____

PHONE WORK: _____ EMERGENCY CONTACT PH: _____

E-MAIL: _____ WHO MAY WE THANK FOR REFERRING YOU TO US?

____ FRIEND / FAMILY (NAME) ?
 ____ WEB SITE ? ____ SEARCH ENGINE? ____ PHONE BOOK? _____

CHIEF COMPLAINT: _____

Date of injury / illness

AUTO CRASH HISTORY If your complaints are NOT auto related, please skip this section & continue to page 2.

Type of accident: Auto Truck Bus Taxi Van Motorcycle Other: _____

Where were you hit from?: Front Rear Left side Right side Top Other: _____

Were you the : Driver Passenger A pedestrian Riding a bike Other? _____

What did you strike? Head Rest Steering wheel Seat Ground Window Pole Door Other: _____

Did you / were you: Trip Mugged Slip-n-Fall Hit by falling object Other: _____

What body part was injured? Head Neck Upper back Low back Arms Legs Knees Elbows

Did you strike your: Head Neck Back Arms Legs Hands Feet

Were there any cuts or bruises? _____

Did you lose consciousness? Yes No If yes, for how long? _____

Were you taken to the hospital? Yes No If yes, which one? _____

Were you kept overnight (admitted)? Yes No If yes, for how long? _____

What treatment did you receive at the hospital? Medication Arm sling Neck collar Crutches Other: _____

Were X-rays taken? Yes No If yes, what was x-rayed? _____

CURRENT HEALTH STATUS

Do you have a family Medical Doctor? No Yes If yes, may we send him / her your treatment records? No yes

Dr's. Name _____
 Address _____
 Phone: _____

What doctors have you seen since this incident / illness?

Name	Specialty	Date
1.		
2.		
3.		

What have you done at home for this condition? Nothing Ice / heat Rest Pain Medication
 What professional treatment has been done thus far? None Neck Collar Physical Therapy Manipulation
 Ice / Heat Braces Ultrasound Other: _____

What are your present symptoms? None Nausea Vomiting Dizziness Fainting Vision Problems
 Nervousness Weakness in Arms / Legs Numbness in Arms / Legs

Pain in the: Head Neck Upper back Lower back Chest Abdomen Shoulders Arms Hands Legs Knees Feet

Difficulty with: Walking Bending Sitting Sleeping Moving of Arms / Legs Other: _____

Since this mishap / crash, have your symptoms become: Worse No improvement Better Slightly better Very much better

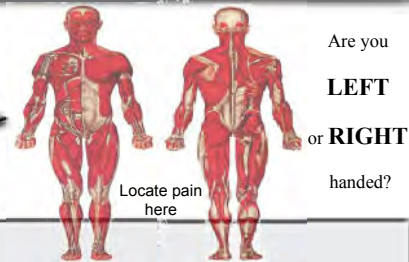
Were you on-the-job when this mishap / crash occurred? No Yes If yes, what were you doing at the time? _____

Have you lost any work due to this mishap / crash? No Yes If yes, how many: Days? Weeks? Months?

Please indicate your degree of symptoms from "0" (no pain) to "10" (extreme pain).

No Pain	Headaches:	0	1	2	3	4	5	6	7	8	9	10
	Neck or Arms:	0	1	2	3	4	5	6	7	8	9	10
	Upper Back:	0	1	2	3	4	5	6	7	8	9	10
	Lower Back or Legs:	0	1	2	3	4	5	6	7	8	9	10

Ext Pain



PAST HISTORY:

Have you ever been under chiropractic care **prior** to this complaint? No Yes If yes, when? _____
 and for what condition? _____

Did you ever have a similar condition / accident? No Yes If yes, when? _____

Have you ever had any serious illness? No Yes If yes, please describe: _____

Do you require medication? No Yes If yes, please identify type: _____

Have you ever had surgery? No Yes If yes, please list type and date below:

1. _____
2. _____
3. _____

Please sign and date this document and acknowledge receiving a copy of your HIPAA Privacy Policy of this office.

Thank You!

Signature & Date