

Patient Case History

HIPAA
Protected Health Information
Authorized Access Only

CONFIDENTIAL

Date _____ Case # _____

Patient/Clinic I.D. # _____ Driver's License # _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Insurance Co. _____ Insurance Phone _____

Sex M F Age _____ Date of Birth _____ Single Married Widowed Separated Divorced

Occupation _____ Shift 1 2 3 Description _____

Employer _____ Work Phone _____ Ext. _____

Work Address _____ Years Worked _____

Spouse _____ List Children _____

Spouse's Social Security _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone _____ Ext. _____

Spouse's Insurance _____ Spouse's Insurance Phone _____

Last Doctor's Name _____ List Medications _____

Care Received _____ List Surgeries _____

Results _____

Are your present problems due to an injury? Yes No On the Job Auto Collision Personal Injury Other

Have you made a report of your accident? Yes No To Employer Auto Carrier Other _____

Has the accident been reported? Yes No Workers' Comp Auto Carrier Other _____

Are you now or have you ever been disabled/impaired? (Service or Work?) Yes No When _____

Have you retained an attorney? Yes No Name & Address _____

CHIEF COMPLAINT / REGIONS OF PAIN

1) _____

2) _____

3) _____

4) _____

HABITS

Smoking Packs/Day _____

Alcohol Cups/Day _____

Coffee Cups/Day _____

Soda Pop Cups/Day _____

EXERCISE

None

Moderate

Daily

Type _____

SEVERITY OF PAIN

List region of pain and circle severity number. (1 = least, 10 = greatest)

MARK PAIN REGION

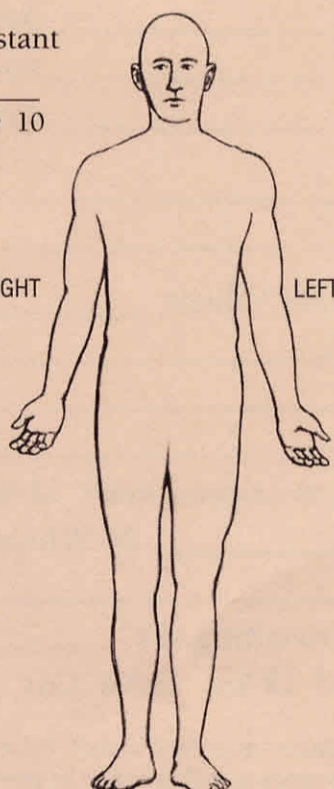
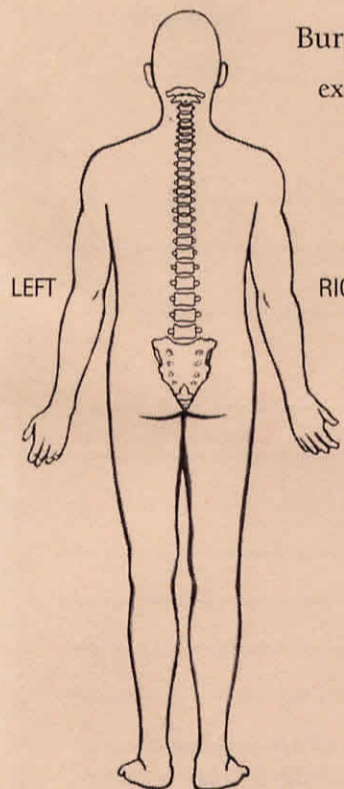
Burning • Stabbing • Sharp • Constant

ex. Neck _____ *sharp*

1 2 3 4 5 6 7 (8) 9 10

MARK PAIN AREA

+++ Burning
000 Stabbing
--- Sharp
!!! Constant
XXX Other



REGIONS

Neck _____
1 2 3 4 5 6 7 8 9 10

Mid Back _____
1 2 3 4 5 6 7 8 9 10

Low Back _____
1 2 3 4 5 6 7 8 9 10

Hips _____
1 2 3 4 5 6 7 8 9 10

Arms _____
1 2 3 4 5 6 7 8 9 10

Legs _____
1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using the code listed above.

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

303.9 Alcoholism 345. Epilepsy 072. Mumps

280. Anemia 240. Goiter 511. Pleurisy

541. Appendicitis 429.9 Heart Disease 480. Pneumonia

716. Arthritis 042. HIV Positive 045. Polio

239. Cancer 487. Influenza 390. Rheumatic Fever

052. Chicken Pox 724.2 Low Back Pain 737.30 Scoliosis

250. Diabetes 055. Measles 846. Sprain/Strain Sacroiliac

690. Eczema 319. Mental Disorder 847.0 Whiplash

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother - Living	Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father - Living	Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adoption History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OFFICE USE ONLY

Patient's Last Physical _____

Patient's Last Lab _____

Patient's Last X-ray _____

Patient's Prostate Exam _____

Patient's Last Pap Smear _____

Patient's Last Breast Exam _____

Patient's Last Spinal Exam _____

Patient's Last Spinal X-ray _____

Patient's Last EMG _____

Patient's Last Infrared Thermography _____

Patient's Last Disc Exam _____

Patient's Last MRI _____ CT Scan _____

Notes _____

PATIENT CASE HISTORY

106a

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable. A complete history and understanding of your health will facilitate care.

GENERAL SYMPTOMS

- ___ 784.0 Headache
- ___ 780.6 Fever
- ___ 780.99 Chills
- ___ 780.8 Night Sweats
- ___ 780.2 Fainting
- ___ 780.4 Dizziness
- ___ 780.3 Convulsions
- ___ 780.52 Loss of Sleep
- ___ 780.7 Fatigue
- ___ 799.2 Nervousness
- ___ 783. Loss of Weight
- ___ 782. Numbness or pain in arms/legs/hands
- ___ 995.3 Allergy (What)
- ___ 786.07 Wheezing
- ___ 729.2 Neuralgia

MUSCLES & JOINTS

- ___ 728.9 Weakness
- ___ 781.0 Twitching
- ___ 723.5 Stiff Neck
- ___ 724.5 Backache
- ___ 719.0 Swollen Joints
- ___ 781. Tremors
- ___ 729.5 Foot Trouble
- ___ 724.79 Painful Tail Bone
- ___ 724.5 Pain Between Shoulders
- ___ 737.3 Spinal Curvature

GASTRO-INTESTINAL

- ___ 783. Poor Appetite
- ___ 536.8 Poor Digestion
- ___ 994.2 Starvation
- ___ 787.3 Belching or Gas
- ___ 787.0 Nausea
- ___ 787.0 Vomiting
- ___ 578.0 Vomiting Blood
- ___ 536.8 Pain over Stomach
- ___ 564.0 Constipation
- ___ 787.91 Diarrhea
- ___ 562.1 Colon Trouble
- ___ 455.6 Hemorrhoids (Piles)
- ___ 776.7 Fluid Retention
- ___ 873.9 Liver Trouble
- ___ 274. Gout
- ___ 782.4 Jaundice
- ___ 575.9 Gall Bladder Trouble

CARDIO-VASCULAR

- ___ 785.0 Rapid Heart
- ___ 427.89 Slow Heart
- ___ 401.9 High Blood Pressure
- ___ 458.9 Low Blood Pressure
- ___ 786.51 Pain Over Heart
- ___ 429.9 Heart Trouble
- ___ 719.07 Swelling Ankles
- ___ 459.9 Poor Circulation
- ___ 454.9 Varicose Veins
- ___ 436. Strokes
- ___ 785.1 Palpitations

EYE/EAR/NOSE/THROAT

- ___ 368.9 Poor Vision
- ___ 378.0 Crossed Eyes
- ___ 379.91 Pain in Eyes
- ___ 389.9 Deafness
- ___ 388.70 Earache
- ___ 388.30 Ear Noises
- ___ 388.60 Ear Discharges
- ___ 478.1 Nasal Obstruction
- ___ 784.7 Nose Bleeds
- ___ 462. Sore Throats
- ___ 784.49 Hoarseness
- ___ 477.9 Hay Fever
- ___ 493.9 Asthma
- ___ 460. Frequent Colds
- ___ 240.9 Enlarged Thyroid
- ___ 463. Tonsillitis
- ___ 473. Sinus Trouble

SKIN OR ALLERGIES

- ___ 680. Skin Eruptions - No
- ___ 698.9 Itching
- ___ 924.9 Bruising Easily
- ___ 701.1 Dryness
- ___ 680.9 Boils
- ___ 782. Sensitive Skin
- ___ 708.9 Hives or Allergy
- ___ 692.9 Eczema
- ___ Medicines
- _____
- _____
- _____

RESPIRATORY

- ___ 786.2 Chronic Cough
- ___ 786.3 Spitting Blood
- ___ 786.4 Spitting Phlegm
- ___ 786.50 Chest Pain
- ___ 786.09 Difficulty Breathing

GENITO-URINARY

- ___ 788.4 Frequent Urination
- ___ 788.1 Painful Urination
- ___ 599.7 Blood in Urine
- ___ 590. Kidney Infection
- ___ 788.3 Bed Wetting
- ___ 788.3 Inability to control Urine
- ___ 601.9 Prostate Trouble

FOR WOMEN ONLY

- ___ 625.3 Painful Periods
- ___ 626.2 Excessive Flow
- ___ 626.4 Irregular Cycle
- ___ 627.2 Hot Flashes
- ___ 625.3 Cramps or Backaches
- ___ 623.5 Vaginal Discharge
- ___ Pregnant at this Time
- ___ Last Pap

By Whom _____
Other _____

IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES - HOSPITALIZATION

DATE	DATE	DATE	DATE
_____ Vaccinations	_____ Other	_____ Rectal Surgery	_____ Thyroid
_____ Tonsillectomy	_____ Tubes in Ears	_____ Other	_____ Stomach
_____ Gall Bladder	_____ Appendectomy	_____ Sinus	_____ Other
_____ Back Operation	_____ Female Organs	_____ Hernia	

Hospital Stays _____

Other Surgeries _____

List any accidents or falls/list dates: Car _____ Recreational Vehicle _____ Sports _____
 School _____ Other _____

List any broken bones (fractures) or dislocations: _____

Have you ever been on crutches? Yes No Why? _____

Have you ever had a lapse of memory? Yes No Have you ever been unconscious? Yes No

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or over-the-counter? Yes No List: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file and x-rays upon request. Copying fees may apply.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

Automobile Accident Questionnaire

Patient's Name: _____ Today's Date: _____

Date of Accident: _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle Type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle Size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

Your position in the vehicle:

- Driver
 Passenger ----- Location ----- Left Middle Right
 Other _____ Front Passenger Rear Passenger Third Seat (rear)

Speed of your vehicle:

- Stopped Moving Moderately Traffic Signal Parking
 Parked Moving Fast Pedestrian Traffic
 Slowing Moving Slowly Stop Sign Busy Intersection
 Moving at approx ____ MPH

Collision Type:

- Driver Side Impact Head on Collision
 Passenger Side Impact Rear Impact
 Front Impact Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle Type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle Size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of Day:

- Full Daylight
 Dawn
 Dusk
 Night

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Ice covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility Compromised By:

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF ACCIDENT:

Were you...

- Totally unaware that the accident was impending
 Aware that the accident was impending
 Aware that the accident was impending & braced for it

Restraints: (check all that apply)

- Seat belt
 Shoulder harness
 No Restraints

If you were the driver of the vehicle, was your foot on the brake pedal? Yes No Knocked off by Impact

Was the air bag deployed?

- Car not equipped with air bag
 Air bag deployed
 Air bag not deployed

What position was YOUR headrest in?

- High position
 Middle position
 High position

Position of your head at time of impact?

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

Position of your body at time of impact?

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

Damage to vehicle you were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totaled
- Unknown

Was your head thrown...?

- Backward and then forward
- Forward, then backward
- To the left To the left, then the right
- To the right To the right, then to the left

Was your body thrown...?

- Backward and then forward
- Forward then backward
- To the left To the left, then the right
- To the right To the right, then the left
- Across the vehicle
- Outside the vehicle Under the vehicle

Citations:

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Left Arm

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Right Arm

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Torso

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Left Leg

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

Right Leg

- Steering wheel Right door
- Dashboard Left window
- Windshield Right window
- Armrest Console
- Headrest Gear shift
- Rear view mirror Front seat
- Left door Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- Yes
- No

Immediately following the accident, did you feel...?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go?

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

Next day discomfort...?

- Increased
- Decreased
- Same

Did your major complaints exist before the accident?

- Yes
- No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Pelvis | | | | | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Pelvis | | | | | |

At the hospital, what areas were you x-rayed?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Pelvis | | | | | |

Where did you experience pain on the day FOLLOWING the accident?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low back | <input type="checkbox"/> Pelvis | | | | | |

FIRST DOCTOR/HOSPITAL/CLINIC

Yes No Were you hospitalized as a result of this accident/ If Yes, where: _____

Doctor 1 Name: _____ Date of first visit: _____

Yes No Were you examined? Yes No Were X-rays taken?

What diagnosis did the doctor give you? _____

Yes No Were you given treatment? If yes, what type? _____
What benefits did you receive from this treatment? _____

Date of last treatment? _____

Yes No Did the doctor refer you to another health professional? If yes, to whom and for what? _____

Yes No Did you follow the doctor's recommendation? If no, why not? _____

SECOND DOCTOR/CLINIC

Doctor 2 Name: _____ Date of first visit: _____

Yes No Were you examined? Yes No Were X-rays taken?

What diagnosis did the doctor give you? _____

Yes No Were you given treatment? If yes, what type? _____
What benefits did you receive from this treatment? _____

Date of last treatment? _____

PRIOR SIMILAR SYMPTOMS

Yes No Did you have any physical complaints just before the accident? If yes, please describe in detail: _____

Yes No Have you ever had any prior injuries, accidents, diseases, or treatment to the area of your body now affected? If yes, what part was previously injured? _____

Date previously injured? _____

Describe previous injury: _____

Yes No Were you treated? By whom? _____

Date treatment began: _____ Date treatment ended: _____

The last date you felt pain or problems from that previous injury: _____

Yes No Have you lost time from work as a result of your injuries? If Yes, how long. _____

Patient's Signature: _____