DU
CHIROPRACTIC

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CASE HISTORY

Name:_____ Date:_____

Address:_____ City:_____ State:____ Zip code:_____

Telephone (Home):_____ (Cell):_____

Email:_____ SS#:_____-_____-_____

Age:_____Birthdate:____/_____/_____ Sex: M / F Status: M S W D No. of Children_____

Occupation:_____ Employer:_____

Spouse's Name:_____ Occupation:_____

Person responsible for this account: Self / Spouse / Parent 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? Yes ☐ No ☐ Explain:_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other: _____

How long has it been since you felt really good?_____List surgical operations: _____

Are you taking any medications?_____ What kind? _____

Any non-prescription drugs? _____ What kind? _____

Other doctors seen for this condition: MD ☐ DC ☐ DO ☐ Other:_____

ACCIDENT INFORMATION:

Did your accident occur while at work? Yes ☐ No ☐ Were you involved in an auto accident? Yes ☐ No ☐

Date:_____ Time:_____ Injury reported to employer? _____ Name of Supervisor:_____

Description of Accident: _____

Were you injured? ____ Were you hospitalized? ____ Where? _____ How long? _____

Have you had any other personal injuries or accidents? _____ When? _____

Do you have an attorney? Yes ☐ No ☐ Name & Address_____

Are you interested in: Relief Care ☐ Corrective Care ☐ Do you want the doctor to choose for you? Yes ☐ No ☐

I understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I decide to terminate my care and treatment, any fees or services rendered to me will be immediately due and payable.

PLEASE CHECK ALL PRESENT SYMPTOMS

Patient Signature:_____ Date:_____

PLEASE CHECK ALL PRESENT SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ Sinus (allergy)
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
- ☐ Migraine
- ☐ Vertigo
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurry vision
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Nausea
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing/buzzing in ears

NECK:
- ☐ Neck pain
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to Left
  - ☐ Turn to Right
  - ☐ Bend to Left
  - ☐ Bend to Right
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Tension in shoulders

ARMS & HANDS:
- ☐ Upper arm pain (R - L)
- ☐ Elbow pain (R - L)
- ☐ Wrist pain (R - L)
- ☐ Pain in hands (R - L)
- ☐ Pain in fingers (R - L)
- ☐ Tingling in arms (R - L)
- ☐ Tingling in fingers (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Joint swollen in fingers (R - L)
- ☐ Loss of grip strength (R - L)

MID-BACK:
- ☐ Mid back pain
- ☐ Pain between shoulder blades
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Rib pain (R - L)
- ☐ Heartburn
- ☐ Shortness of breath
- ☐ Pain upon breathing

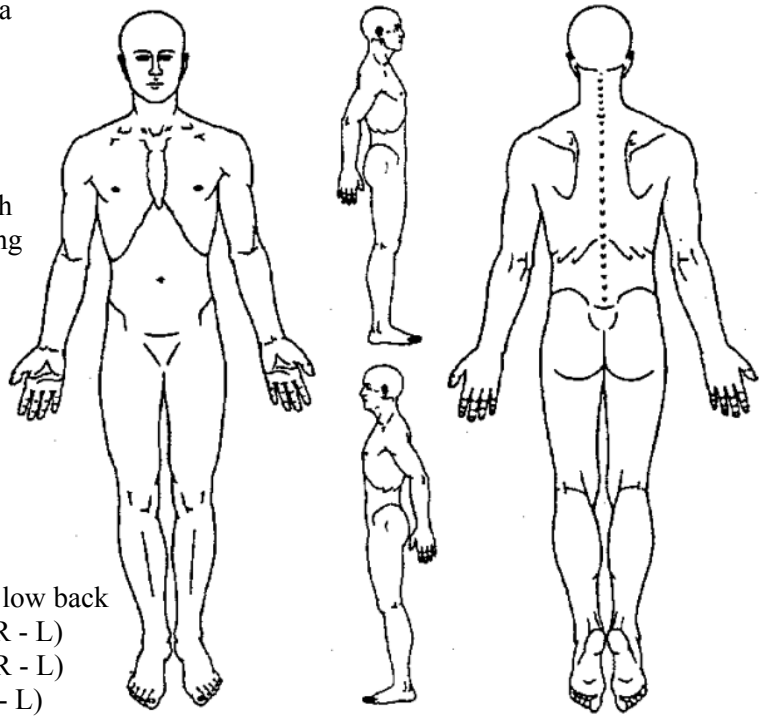
ABDOMEN:
- ☐ Upset Stomach
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Pain after eating

LOW BACK:
- ☐ Low back pain
- ☐ Muscle spasms in low back
- ☐ Pain in hip joint (R - L)
- ☐ Pain in buttocks (R - L)
- ☐ Pain down leg (R - L)
- ☐ Numbness in leg (R - L)
- ☐ Numbness in feet (R - L)
- ☐ Numbness in toes (R - L)
- ☐ Knee pain (R - L)
- ☐ Ankle pain (R - L)
- ☐ Leg cramps (R - L)

PAIN WHEN:
- ☐ Bending
- ☐ Lifting
- ☐ Twisting
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Coughing
- ☐ Sleeping
- ☐ Working

GENERAL:
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Loss of sleep
- ☐ Gain/loss of weight___lbs
- ☐ Diabetes
- ☐ Other:_____

CIRCLE AREAS OF COMPLAINT:



DOCTOR'S REMARKS:

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Height: **Pulse:**

Weight: **BP:**