Case History

Date: _____ # _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: (Street #) _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (Home) _____ (Work) _____ BEST TIME TO CALL: ___AM ___PM

EMAIL ADDRESS: _____

TEXT REMINDERS: YES___ NO___ BEFORE VISIT: 1hr 4hrs 1 day CELL PROVIDER: _____

SS#: _____ SPOUSES NAME: _____ No. OF CHILDREN _____

YOUR OCCUPATION: _____ EMPLOYER: _____ TYPE OF WORK: _____

NAME OF EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

REFERRED TO THIS OFFICE BY: _____ (Website/Google, Friend, Dr., Etc.)

HAVE YOU RECEIVED CHIROPRACTIC CARE BEFORE? YES___ NO___ WHEN? _____ WHERE? _____

DO YOU HAVE HEALTH INSURANCE? YES___ NO___ NAME OF INSURANCE: _____

NAME OF INSURED: _____ RELATIONSHIP: _____

SPOUSES INSURANCE CO. NAME: _____ MEDICAID: YES___ NO___ MEDICARE: YES___ NO___

ARE YOUR PRESENT PROBLEMS, COMPLAINTS, INJURIES DUE TO:

____ AUTO RELATED ACCIDENT/ ____ ON THE JOB INJURY/ ____ PERSONAL INJURY (fall, etc.) DATE OF INJURY _____

PLEASE LIST YOUR HEALTH COMPLAINT(S)/SYMPTOMS:

A _____
B _____
C _____
D _____

DR'S COMMENTS

PLEASE CIRCLE (Y) FOR <u>YES</u> or (N) FOR <u>NO</u>:

Have you seen any doctors for your current problems? Y N

Have you been hospitalized for any current problems? Y N

Has there been any changes in your bodily functions (urination, bowel habits, respiration, digestion, vision, sexual function, other)? Y N;
If yes, explain: _____

Have you found anything that makes your problem <u>better</u> (rest, morning, evening, certain positions...)? Y N;
If yes, explain: _____

Have you found anything that makes your problem <u>worse</u> (positions, activities, morning, evening, coughing, sneezing, straining when moving your bowels, other)? Y N; If yes, explain: _____

_____

Does your condition / pain awaken you from sleep? Y N; If yes, explain: _____

Does your condition affect work activities in any way? Y N; If yes, explain: _____

Have you had <u>time</u> loss from work or school? Y N; If yes, explain: _____

Do you have any congenital (born with) factors which relate to your condition? Y N; If yes, explain: _____

_____

Are you suffering from any conditions and/or disabling conditions other than those you are consulting us for? Y N;
If yes, explain: _____

What medications or drugs are you taking and why? _____

_____

Do you have any family history of the following conditions (please circle)

Diabetes Heart Kidney Cancer Back Stroke Arthritis Other _____

Place a "**B**", if you have experienced any of the following BEFORE, a "**N**" if you are experiencing any NOW, or "**B&N**" if both apply. Circle R for right and L for left, when appropriate.

___ Headache
___ Behind the Eyes
___ Forehead
___ Temples
___ Migraine
___ Pressure
___ Head Feels Heavy
___ Loss of Memory
___ Light-Headedness
___ Fainting
___ Dizziness
___ Fatigue
___ Weakness
___ Blurred Vision
___ Light Bothers Eyes
___ Loss of Consciousness
___ Loss of Smell
___ Loss of Taste
___ Loss of Balance
___ Loss of Hearing
___ Ear Problems
___ Ringing in Ears
___ Poor Vision

___ Eye Problems
___ Sinus Problems
___ Nasal Problems
___ Thyroid Problems
___ Throat Problems
___ Frequent Colds
___ Low Resistance
___ Nervousness
___ Depression
___ Convulsions/Seizures
___ Epilepsy
___ Nausea
___ Vomiting
___ Speech Problems
___ Abnormal Weight Loss
___ Chest Pain
___ Rib Pain
___ Heart Problems
___ High Blood Pressure
___ Low Blood Pressure
___ Respiratory (Breathing) Problems
___ Asthma

___ Stroke
___ Breast Problems
___ Stomach Problems
___ Ulcers
___ Digestive Problems
___ Hernias (Hiatal, Inguinal, etc.)
___ Gall Bladder Problems
___ Liver Problems
___ Colon Problems
___ Constipation
___ Diarrhea
___ Kidney Problems
___ Urinary Problems
___ Hemorrhoids
___ Female Organ Trouble
___ Menstrual Problems
___ Prostrate Problems
___ Tailbone Problems
___ Sacroiliac Problems
___ Poor Circulation
___ Cold Hands R/L
___ Cold Feet R/L

___ Loss of Grip Strength R/L
___ Swelling
Where?_____
___ Swollen Joint(s)
Where?_____
___ Leg Cramping R/L
___ Foot Cramping R/L
___ Arthritis
Where?_____
___ Rheumatoid Arthritis
___ Psoriatic Arthritis
___ Osteoporosis
___ Bursitis
___ Psoriasis
___ Muscle Disease
What type?_____
___ Diabetes/Insulin Dependent? Y/N
or Diet Controlled? Y/N
___ Cancer
Where?_____
What Type?_____
_____

___ Polio
___ Alcoholism
___ AIDS
___ Syphilis
___ Sexually Transmitted Diseases (What Type?)
_____
___ Mental Disorder
___ Bone Disease
___ Arteriosclerosis
___ Pacemaker
___ Breast Alteration
___ Plastic Surgery
___ Hip Replacement
___ Artificial Joints

Any chance of Pregnancy AT THIS TIME? Y/N

Pain in:			Numbness in:			Pins and Needles in:			Neck:	Midback:	Lowback:
___ Arms	R	L	___ Arms	R	L	___ Arms	R	L	___ Pain	___ Pain	___ Pain
___ Hands	R	L	___ Hands	R	L	___ Hands	R	L	___ Spasm	___ Spasm	___ Spasm
___ Knee	R	L	___ Legs	R	L	___ Legs	R	L	___ Stiffness	___ Stiffness	___ Stiffness
___ Legs	R	L	___ Feet	R	L	___ Feet	R	L	___ Grinding	___ Grinding	___ Grinding
___ Feet	R	L							___ Popping	___ Popping	___ Popping
___ Hips	R	L							___ Pinched Nerve	___ Pinched Nerve	___ Pinched Nerve

Please bring in past health records and x-rays so they may be reviewed.

PLEASE EXPLAIN AND GIVE DATES

List any **recent** and/or **past:**

Accidents, falls, or injuries: _____

_____

Broken Bones/ Dislocations: _____

a) Fractures of the spine/vertebrae: _____

Sprains or Strains: _____

Spinal Surgeries: _____

Any other surgeries / operations: _____

Spinal Injections: _____

Spinal (Back) Treatment: _____

Illnesses/Diseases: _____

Specialized Tests Performed, i.e. (E.MG., EEG, EKG, M.R.I., CAT SCAN, BONE SCAN, MYELOGRAM, BLOOD TESTS, OTHER...)

_____

Physical Therapy Treatment: _____

X-Rays Performed: _____

Doctor Visits: _____

Hospital Visits or Stays: _____

Please list any additional comments you wish to make regarding your condition: _____

_____

It is understood and agreed that the amount paid Radix Chiropractic for x-rays is for evaluation only and the x-ray negatives will remain the property of this office.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____