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

SS# _____SPOUSES NAME: _____ No. OF CHILDREN_____

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

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

REFFERED TO THIS OFFICE BY:_____(Family, Friend, Dr., Internet, 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 INS. 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

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

_____

Have you had any <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 <u>other than</u> 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 Loss of Weight
____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
____Prostate Problems

____Tailbone Problems
____Sacroiliac Problems
____Poor Circulation
____Cold Hands R/L
____Cold Feet R/L
____Loss of Grip Strength R/L
____Swelling
Where? _____
____Swollen Joints
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
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

Y N Any chance of Pregnancy AT THIS TIME? (circle 1)

Pain In:	Numbness In:	Pins and Needles In:	Neck:	Midback:	Lower Back:
____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
____Hip 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.M.G., EEG, EKG, M.R.I., CAT SCAN, BONE SCAN, MYELOGRAM, BLOOD TESTS, OTHER…)_____
Physical Therapy: _____
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 to Waverly Chiropractic Center, PLLC for x-rays is for evaluation only and the x-ray negatives will remain the property of this office.

Patient's Signature: _____ Date: _____

EMAIL ADDRESS: _____