

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 / SPINAL REGIONS OF PAIN

- 1) Neck _____
- 2) Back _____
- 3) Hips _____
- 4) Arms/Hands _____
- 5) Legs/Feet _____

HABITS

- Smoking Packs/Day _____ None
- Alcohol Cups/Day _____ Moderate
- Coffee Cups/Day _____ Daily
- Soda Pop Cups/Day _____ Type _____

EXERCISE

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

- 1) Neck _____
1 2 3 4 5 6 7 8 9 10
- 2) Mid Back _____
1 2 3 4 5 6 7 8 9 10
- 3) Low Back _____
1 2 3 4 5 6 7 8 9 10
- 4) Hips _____
1 2 3 4 5 6 7 8 9 10
- 5) Arms/Hands _____
1 2 3 4 5 6 7 8 9 10
- 6) Legs/Feet _____
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?

- | | | |
|--|---|--|
| <input type="checkbox"/> 303.9 Alcoholism | <input type="checkbox"/> 345. Epilepsy | <input type="checkbox"/> 072. Mumps |
| <input type="checkbox"/> 280. Anemia | <input type="checkbox"/> 240. Goiter | <input type="checkbox"/> 511. Pleurisy |
| <input type="checkbox"/> 541. Appendicitis | <input type="checkbox"/> 429.9 Heart Disease | <input type="checkbox"/> 480. Pneumonia |
| <input type="checkbox"/> 716. Arthritis | <input type="checkbox"/> 042. HIV Positive | <input type="checkbox"/> 045. Polio |
| <input type="checkbox"/> 239. Cancer | <input type="checkbox"/> 487. Influenza | <input type="checkbox"/> 390. Rheumatic Fever |
| <input type="checkbox"/> 052. Chicken Pox | <input type="checkbox"/> 724.2 Low Back Pain | <input type="checkbox"/> 737.30 Scoliosis |
| <input type="checkbox"/> 250. Diabetes | <input type="checkbox"/> 055. Measles | <input type="checkbox"/> 846. Sprain/Strain Sacroiliac |
| <input type="checkbox"/> 690. Eczema | <input type="checkbox"/> 319. Mental Disorder | <input type="checkbox"/> 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"/>	<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"/>	<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

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