Patient Case History

HIPAA
Protected Health Information
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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

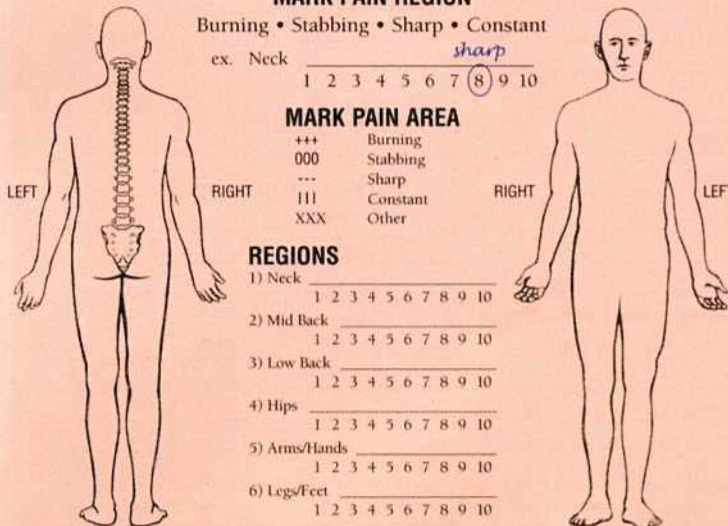
❑ Smoking	Packs/Day	________
❑ Alcohol	Cups/Day	________
❑ Coffee	Cups/Day	________
❑ Soda Pop	Cups/Day	________

EXERCISE

❑ None
❑ Moderate
❑ Daily
Type ________

SEVERITY OF PAIN

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



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❑ N❑	❑	❑	❑	❑	❑
Father – Living Y❑ N❑	❑	❑	❑	❑	❑
Brother(s), # of ____	❑	❑	❑	❑	❑
Sister(s), # of ____	❑	❑	❑	❑	❑
Adoption History	❑	❑	❑	❑	❑

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 ______________

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