

# Patient Case History

**HIPAA Protected Health Information  
Authorized Access Only**

**CONFIDENTIAL**

Date \_\_\_\_\_ Patient/Clinic ID # \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Single  Married  Widowed  Divorced  Other \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Spouse \_\_\_\_\_ # of Children \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Insured's Name \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Emergency Contact and Number \_\_\_\_\_

Are your present problems due to an injury?  Yes  No  Reported Work Injury  Auto Collision  Other \_\_\_\_\_

Have you made a report of your accident?  Yes  No Have you retained an attorney?  Yes  No Name \_\_\_\_\_

### Chief Complaint/Severity of Pain

### Habits

### Exercise

List region of pain and circle the severity number (1 = least, 10 = Greatest)

- 1) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10  Smoking Packs/Day \_\_\_\_\_  None
- 2) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10  Alcohol Drinks/Day \_\_\_\_\_  Light
- 3) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10  Coffee Cups/Day \_\_\_\_\_  Moderate
- 4) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10  Soda/Pop Cans/Day \_\_\_\_\_  Intense

### Mark Pain Region and Area

++++ Burning 00000 Stabbing  
 ----- Sharp IIIIII Constant XXXX Other



### Have You Had Any of The Following Diseases?

- Alcoholism  Epilepsy  Scoliosis  Anemia  Goiter  Diabetes  
 Pleurisy  Appendicitis  Heart Disease  Pneumonia  Whiplash  
 Arthritis  HIV Positive  Polio  Influenza  Mental Disorder  
 Rheumatic Fever  Cancer Type \_\_\_\_\_  
 Chicken Pox  Measles  Mumps  Low Back Pain  Scoliosis

### Family History

	Y	N	Diabetes	Heart	Kidney	Cancer	Back
Mother - Living <input type="checkbox"/> Age _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father - Living <input type="checkbox"/> Age _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s) # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s) # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes \_\_\_\_\_

### OFFICE USE ONLY

Patient's Last Physical \_\_\_\_\_ Last Prostate Exam \_\_\_\_\_

Last Lab \_\_\_\_\_ Last Doctor's Name \_\_\_\_\_

Last X-ray \_\_\_\_\_ Medications \_\_\_\_\_

Last Advanced Imaging \_\_\_\_\_

Facility Location \_\_\_\_\_ Tests \_\_\_\_\_

Last Pap Smear and Breast Exam \_\_\_\_\_ Notes \_\_\_\_\_

**PATIENT CASE HISTORY** Patient Name \_\_\_\_\_

A complete history and understanding of your health will facilitate care.

Please enter a "2" for Previously, a "3" for Presently in front of all of the following signs and symptoms. Leave blank if not applicable.

**GENERAL SYMPTOMS**

- \_\_\_ 784.0 Headache
- \_\_\_ 780.6 Fever
- \_\_\_ 780.99 Chills
- \_\_\_ 780.8 Night Sweats
- \_\_\_ 780.2 Fainting
- \_\_\_ 780.4 Dizziness
- \_\_\_ 780.3 Convulsions
- \_\_\_ 780.52 Loss of Sleep
- \_\_\_ 780.7 Fatigue
- \_\_\_ 799.2 Nervousness
- \_\_\_ 783. Loss of Weight
- \_\_\_ 782. Numbness or pain  
In arms/legs/hands
- \_\_\_ 995.3 Allergy \_\_\_\_\_
- \_\_\_ 786.07 Wheezing
- \_\_\_ 729.2 Neuralgia

**GASTRO-INTESTINAL**

- \_\_\_ 783.0 Poor Appetite
- \_\_\_ 536.8 Poor Digestion
- \_\_\_ 994.2 Starvation
- \_\_\_ 787.3 Belching or Gas
- \_\_\_ 787.0 Vomiting
- \_\_\_ 578.0 Vomiting Blood
- \_\_\_ 536.8 Pain over Stomach
- \_\_\_ 564.0 Constipation
- \_\_\_ 787.91 Diarrhea
- \_\_\_ 562.1 Colon Trouble
- \_\_\_ 455.6 Hemorrhoids (Piles)
- \_\_\_ 776.7 Fluid Retention
- \_\_\_ 873.9 Liver Trouble
- \_\_\_ 782.4 Jaundice
- \_\_\_ 575.9 Gall Bladder Trouble
- \_\_\_ 274. Gout

**EYE/EAR/NOSE/THROAT**

- \_\_\_ 368.9 Poor Vision
- \_\_\_ 378.0 Crossed Eyes
- \_\_\_ 379.91 Pain in Eyes
- \_\_\_ 389.9 Deafness
- \_\_\_ 388.70 Earache
- \_\_\_ 388.30 Ear Noises
- \_\_\_ 388.60 Ear Discharges
- \_\_\_ 478.1 Nasal Obstruction
- \_\_\_ 784.7 Nose Bleeds
- \_\_\_ 462. Sore Throats
- \_\_\_ 784.49 Hoarseness
- \_\_\_ 477.9 Hay Fever
- \_\_\_ 493.9 Asthma
- \_\_\_ 460. Frequent Colds
- \_\_\_ 240.9 Enlarged Thyroid
- \_\_\_ 473. Sinus Trouble

**RESPIRATORY**

- \_\_\_ 786.2 Chronic Cough
- \_\_\_ 786.3 Spitting Blood
- \_\_\_ 786.4 Spitting Phlegm
- \_\_\_ 786.50 Chest Pain
- \_\_\_ 786.09 Difficulty Breathing

**GENITO-URINARY**

- \_\_\_ 788.4 Frequent Urination
- \_\_\_ 788.1 Painful Urination
- \_\_\_ 590. Kidney Infection
- \_\_\_ 788.3 Bed Wetting
- \_\_\_ 788.3 Inability to Control Urine
- \_\_\_ 601.9 Prostate Trouble

**MUSCLES & JOINTS**

- \_\_\_ 728.9 Weakness
- \_\_\_ 781.0 Twitching
- \_\_\_ 723.5 Stiff Neck
- \_\_\_ 724.5 Backache
- \_\_\_ 719.0 Swollen Joints
- \_\_\_ 781. Tremors
- \_\_\_ 729.5 Foot Trouble
- \_\_\_ 724.79 Painful Tail bone
- \_\_\_ 724.5 Pain Between Shoulders
- \_\_\_ 737.3 Spinal Curvature

**CARDIO-VASCULAR**

- \_\_\_ 785.0 Rapid Heart
- \_\_\_ 427.89 Slow Heart
- \_\_\_ 401.9 High Blood Pressure
- \_\_\_ 458.9 Low Blood Pressure
- \_\_\_ 429.9 Heart Trouble
- \_\_\_ 719.07 Swelling Ankles
- \_\_\_ 459.9 Poor Circulation
- \_\_\_ 454.9 Varicose Veins
- \_\_\_ 436. Strokes
- \_\_\_ 785.1 Palpitations

**SKIN OR ALLERGIES**

- \_\_\_ 680. Skin Eruptions
- \_\_\_ 698.9 Itching
- \_\_\_ 924.9 Bruising Easily
- \_\_\_ 701.1 Dryness
- \_\_\_ 680.9 Boils
- \_\_\_ 782. Sensitive Skin
- \_\_\_ 708.9 Hives
- \_\_\_ 692.9 Eczema
- Notes \_\_\_\_\_

**FOR WOMEN ONLY**

- \_\_\_ 625.3 Painful Periods
- \_\_\_ 626.2 Excessive Flow
- \_\_\_ 626.4 Irregular Cycle
- \_\_\_ 627.5 Hot Flashes
- \_\_\_ 625.3 Cramps or Backaches
- \_\_\_ 623.5 Vaginal Discharge
- Are you pregnant?  Yes  No
- OBGYN \_\_\_\_\_
- Notes \_\_\_\_\_

**IN PATIENT/OUT PATIENT OPERATIONS AND PROCEDURES**

DATE	DATE	DATE	DATE
Back Surgery _____	Tonsillectomy _____	Tubes in Ears _____	Childbirth _____
Knee Surgery _____	Shoulder _____	Gall Bladder _____	Other _____
Neurological _____	Sinus _____	Appendectomy _____	Other _____
Thyroid _____	Hernia _____	Stomach _____	Other _____
Female _____	Rectal _____	Plastic Surgery _____	Other _____
Other Procedures _____			

Hospital Stays \_\_\_\_\_

Accidents/Falls (please list dates) \_\_\_\_\_

List any broken bones (fractures) or dislocations: \_\_\_\_\_

Have you ever had a lapse of memory?  Yes  No    Have you ever been unconscious?  Yes  No

Have you ever had x-rays taken?  Yes  No \_\_\_\_\_

Are you presently taking any medications – prescription or over-the-counter?  Yes  No \_\_\_\_\_

Do you suffer from any other condition other than for which you are now consulting us? \_\_\_\_\_

I understand and agree that health and accident insurance policies are arrangement between an insurance carrier and myself. Furthermore, I understand that Hammer Chiropractic, LLC. will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Hammer Chiropractic, LLC. to be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if they suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these services to be performed. It is understood and agreed the amount paid for the x-rays is for the examination only and the x-ray data will remain the property of this office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at Hammer Chiropractic. Dr. Hammer will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their files and x-ray upon written request. Copy fees may apply.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

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