Patient Case History

HIPAA Protected Health Information
Authorized Access Only

CONFIDENTIAL

Date_____ Patient/Clinic ID #_____

Full Name_____ Nickname_____

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

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

1)_____ 1 2 3 4 5 6 7 8 9 10

2)_____ 1 2 3 4 5 6 7 8 9 10

3)_____ 1 2 3 4 5 6 7 8 9 10

4)_____ 1 2 3 4 5 6 7 8 9 10

Habits

Smoking /Tobacco ☐ **Never** ☐ **Former** ☐ **Current** **Use per Day**_____

☐ Alcohol Drinks/Day _____

☐ Coffee Cups/Day _____

☐ Soda/Pop Cans/Day _____

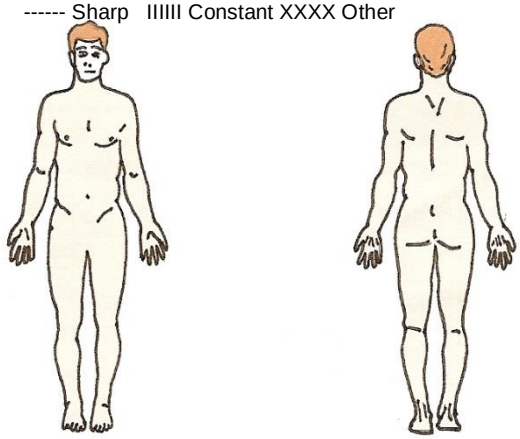
Exercise

☐ None
☐ Light
☐ Moderate
☐ Intense

Duration____
_____

Mark Pain Region and Area

++++ Burning 00000 Stabbing
----- Sharp IIIII 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

Family History

	Y	N		Diabetes	Heart	Kidney	Cancer	Back
Father - Living	☐	☐	Age____	☐	☐	☐	☐	☐
Mother – Living	☐	☐	Age____	☐	☐	☐	☐	☐
Brother(s) #_____				☐	☐	☐	☐	☐
Sister(s) #_____				☐	☐	☐	☐	☐

Notes_____

OFFICE USE ONLY

Patient's Last Physical_____(WNL) Last Prostate Exam_____(WNL) Last Pap Smear/Breast Exam_____ (WNL)

Last Lab_____(WNL) Doctor/Facility Name_____
Previous Chiropractor_____ Tests _____

Last X-ray_____ Last Advanced Imaging_____
Medications_____

External Cause_____ QC MU

11/15

PATIENT CASE HISTORY Patient Name_____

CONFIDENTIAL

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.

NEUROLOGICAL
___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Numbness L R B
In arms/legs/hands/feet
___ Twitching
___ Tremors
___ Wheezing
___ Neuralgia
___ Depression

CARDIO-VASCULAR
___ Rapid Heart
___ Slow Heart
___ High Blood Pressure
___ Low Blood Pressure
___ Heart Trouble
___ Swelling Ankles
___ Poor Circulation
___ Varicose Veins
___ Strokes/TIA
___ Palpitations
___ High Cholesterol

MUSCLES & JOINTS
___ Weakness
___ Neck pain
___ Mid Back pain
___ Low Back pain
___ Knee pain L R
___ Shoulder pain L R
___ Swollen Joints
___ Foot Trouble
___ Painful Tail bone
___ Pain Between Shoulders
___ Pain/Ache in legs/feet L R B
___ Pain/Ache in arms/hands L R B
___ Gout

GASTRO-INTESTINAL
___ Poor Appetite/Digestion
___ Belching or Gas
___ Vomiting
___ Pain over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids (Piles)
___ Fluid Retention
___ Liver Trouble
___ Jaundice
___ Gall Bladder Trouble
___ Acid Reflux

EYE/EAR/NOSE/THROAT
___ Poor Vision
___ Crossed Eyes
___ Pain in Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Ear Discharges
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throats
___ Hoarseness
___ Frequent Colds
___ Enlarged Thyroid
___ Sinus Trouble

SKIN OR ALLERGIES
___ Skin Eruptions
___ Itching
___ Bruising Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Hives
___ Eczema
___ Psoriasis
___ Rosacea
___ Shingles
___ Allergy _____
_____
_____

RESPIRATORY
___ Chronic Cough
___ Spitting Blood
___ Spitting Phlegm
___ Chest Pain
___ Difficulty Breathing
___ Asthma

GENITO-URINARY
___ Frequent Urination
___ Painful Urination
___ Kidney Infection
___ Bed Wetting
___ Inability to Control Urine
___ Prostate Trouble

FOR WOMEN ONLY
___ Painful Periods
___ Excessive Flow
___ Irregular Cycle
___ Hot Flashes
___ Cramps or Backaches
___ 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(s)_____
Knee Surgery _____	Shoulder _____	Gall Bladder _____	Other _____
Neck Surgery _____	Sinus _____	Appendectomy _____	Other _____
Thyroid _____	Hernia _____	Stomach _____	Other _____
Female _____	Rectal _____	Plastic Surgery _____	Other _____

Other Procedures_____
_____
_____
Hospital Stays_____
_____
Accidents/Falls (please list dates)_____(Resolved)
_____
List any broken bones (fractures) or dislocations:_____
_____
Have you ever had a lapse of memory? □ Yes □ No Have you ever been unconscious? □ Yes □ No Concussions? □ Yes □ No
Have you ever had x-rays taken? □ Yes □ No _____
_____
Do you have **allergies to any medications**?_____
_____
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 an 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_____