

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

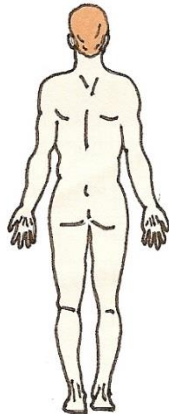
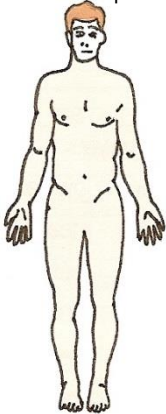
2) _____ 1 2 3 4 5 6 7 8 9 10

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

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

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

Family History

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

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.

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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 _____