



CASE HISTORY

(Please print)

FULL NAME: _____ TODAY'S DATE: _____

ADDRESS: _____ APT# _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____ SSN# _____

BIRTHDATE: ___/___/___ AGE: _____ SEX: ___M___F STATUS: ___M___S___W___D # CHILDREN _____

EMPLOYER'S INFORMATION

OCCUPATION: _____ EMPLOYER _____ YRS EMPLOYED: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____ PHONE# _____

SPOUSE'S NAME: _____ OCCUPATION _____ EMPLOYER _____

PERSON RESPONSIBLE FOR ACCOUNT _____ REFERRED BY _____

WHAT IS YOUR MAJOR COMPLAINT? HOW DID IT BEGIN?

Is this? Work related Auto related N/A

1. How long have you had this condition? _____

2. Have you had this or similar conditions in the past? _____

3. What activities aggravate your condition? _____

4. Is this condition getting progressively worse? Yes No Constant Comes and goes

5. Is this condition interfering with your: Work Sleep Daily routine Other _____

6. How long has it been since you really felt good? _____

7. List surgical operations and dates performed: _____

8. Are you taking any medications? _____ If so, what kind? _____

9. Other doctors seen for this condition: ___MD___DC___DO___DDS

Doctor's Name: _____ Practice Name: _____ Diagnosis: _____ Date: _____

10. Rate your pain on the scale below (how you feel today):

No Pain Unbearable Pain

11. How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

12. Have you had spinal x-rays, MRI, or CT Scan? Yes No Date(s) taken and what area? _____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered, and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____ **Email (eNewsletter):** _____