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### CASE HISTORY

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

#### Chief Complaint

What are the symptoms that brought you in to our office? \_\_\_\_\_

Are your symptoms a result of an accident or injury:  Yes  No

If "Yes" was the accident/injury related to:  Work  Auto

Please describe the accident or injury: \_\_\_\_\_

Have any days of work been lost as a result of your symptoms?  Yes  No

If "Yes" how many and when? \_\_\_\_\_

#### Medical History

Name of your Family Medical Doctor: \_\_\_\_\_

Medical Doctor Address & Phone No: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Findings: \_\_\_\_\_

Do we have permission to submit reports regarding your care to your MD?  Yes  No

#### Past Conditions

Have you had or do you now have any of the following conditions?

**C** = Currently **P** = Previously

##### Musculo-skeletal

C P Headaches

C P Neck Pain

C P Back Pain

C P Shoulder/Arm Pain

C P Hip/Leg Pain

C P Arms/Hands Numbness

C P Muscle Spasms

C P Joint Pain/Swelling

##### Constitutional

C P Fever

C P Unexplained Weight Loss/Gain

##### Eyes/Ears/Nose/Throat

C P Light Bothers Eyes

C P Ringing/Buzzing in Ears

##### Cardiovascular

C P Chest Pains/Tightness

C P High Blood Pressure

C P Problems Breathing

C P Cold Hands/Feet

C P Circulatory Problems

C P Stroke

C P Heart Problems

##### Gastrointestinal

C P Digestive Problems

##### Genito-urinary

C P Difficulty Urinating

##### Neurological

C P Nervousness

C P Irritability

C P Memory Loss

C P Epilepsy

C P Seizures/Convulsions

##### Other

C P Cancer

C P Rheumatoid Arthritis

C P Osteoarthritis

C P Fatigue

C P Fainting

C P Frequent Colds

C P Diabetes

C P Menstrual Difficulties

C P Sleeping Problems

C P Eating Disorder

C P Alcoholism

