Chirpractic_physical_therapy_form

CONFIDENTIAL PATIENT CASE HISTORY

date _____ social security number _____ drivers license number _____

name _____ address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

birth date _____ age _____ sex ☐ Male ☐ Female

business or employer _____ type of work _____

business address and phone number _____

check one ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

number of children _____

name and number of emergency contact _____

spouse name _____ occupation _____ employer _____

who is responsible for your bill ☐ Self ☐ Spouse ☐ Workmans Comp ☐ Medicaid ☐ Medicare ☐ Auto Insurance ☐ Personal health insurance

other _____

CURRENT HEALTH CONDITION

purpose of this appointment

other doctors seen for this condition

when did this condition begin

check ☐ Gradual Onset ☐ Job Related ☐ Auto Related

medication you now take ☐ Nerve Pills ☐ Pain Killers or Muscle relaxers ☐ Insulin ☐ Blood pressure medicine

others

PAST HEALTH HISTORY

major surgery or operations ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ BrokenBone

otherone

major accidents or falls

hospitalization if other than above

previous chiropractic care ☐ None

doctors name

appox date of last visit

Indicate ability to perform the following activities:

coughing or sneezing

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

climbing

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

getting in and out of a car

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

kneeling

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

bending forward to brush teeth

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

balancing

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

turing over in bed

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

dressing self

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

walking short distance

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

sleeping

- ◇
- ◇ U-unable
- ◇ P-painful
- ◇ D-Diificult
- ◇ L-Limited
- ◇ N-Normal

standing more than one hour

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

stooping

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

sitting at table

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

gripping

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

lying on back

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

pushing

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

lying flat on stomach

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

pulling

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

lying on side with knees bent

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

reaching

◇
◇ U-unable
◇ P-painful
◇ D-Diificult
◇ L-Limited
◇ N-Normal

bending over forward	◇ ◇ U-unable ◇ P-painful ◇ D-Diificult ◇ L-Limited ◇ N-Normal	sexual activity	◇ ◇ U-unable ◇ P-painful ◇ D-Diificult ◇ L-Limited ◇ N-Normal

checking symptoms of nervous syatems ☐ Blurring Vision ☐ buzzing or ringing in ears ☐ confusion ☐ convulsions ☐ depression or crying spells ☐ dizziness ☐ fainting ☐ paralysis ☐ loss of sleep ☐ low resistance ☐ muscle jerking ☐ headaches

how often do you have headaches

symptoms are better in ☐ AM ☐ Midday ☐ PM

symptoms are worse in ☐ AM ☐ Midday ☐ PM

symptoms do not change with time of day ☐

For woman only

are you pregnant ☐ Yes ☐ No

date of onset of last menstrual cycle

give date of last xray

what body part were they taken of

Family History:

cancer ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ None

diabetes ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ None

heart problems ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ None

back or neck problems ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ None

Accident Information

have you retained an attorney ☐ Yes ☐ no

If yes

attorney name _____ attorney address _____

attorney phone _____

number of people in vechicle and their name _____

were the policy notified ☐ Yes ☐ no

what direction were you headed ☐ North ☐ East ☐ South ☐ West

what direction was other vechicle ☐ North ☐ East ☐ South ☐ Wst

name of street or town _____

were you struck from ☐ behind ☐ front ☐ left side ☐ right side

in your own words please describe accident

_____

_____

_____

_____

please complaints and symptoms

_____

_____

_____

_____

did you lose any time from work ☐ Yes ☐ No

date when you lose from work _____

type of employment _____

where were you taken immediately following accident _____

if taken to the hospital did you ☐ Go by ambulance ☐ Drove self ☐ Taken by someone else

have you ever been involved in an accident before ☐ yes ☐ no