

# Case History – Update

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

First

Middle

Last

## GENERAL INFORMATION

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Cell Carrier: AT&T / Sprint / \_\_\_\_\_ e-mail address or alt phone : \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male - Female Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Drivers Lic #: \_\_\_\_\_

Marital Status: S / M / D / W Which hand do you write with?: R / L / Both Ht: \_\_\_\_ Wt: \_\_\_\_ lbs. Spouse's Name: \_\_\_\_\_

Reason / Purpose of This Appointment: \_\_\_\_\_

## SYMPTOMS & ILL HEALTH (Present State of Ill Health)

Present Complaint/s: \_\_\_\_\_

Major complaint: \_\_\_\_\_

Pain or problem started on: \_\_\_\_\_ Any previous episodes of same condition? \_\_\_\_\_

**Any other complaints or symptoms (please check all that apply):**

- Neck pain  Stiff neck  Pins/needles in legs  Pins/needles in arms  Fainting  Cold hands  Cold feet  
 Back pain  Numbness in fingers  Numbness in toes  Difficulty chewing  Insomnia  Headaches  
 Double vision  Constipation  Reduced hearing  Loss of taste  Loss of smell  Flushed face  
 Eyes sensitive to light  Nervousness  Tension  Irritability  Lightheaded  Ringing in ears  
 Buzzing in ears  Diarrhea  Upset stomach  Extreme fatigue  Reduced appetite  Weight gain  
 Weight loss  Abdominal pain  Dark black stool  Bright red stool  Coughing  Restlessness  Depression  
 Dizziness  Loss of balance  Excessive sweat  Cold sweats  Dry mouth  Bloating  Blurred vision  
 Nausea  Poor memory  Vomiting  Difficulty swallowing  Difficulty breathing  Shortness of breath  
 Blood in urine  Pain on urination  Sinus problems  Menstrual irregularity  Vaginal pain/infections  
 Breast/Chest pain or lumps  Prostate/Sexual dysfunction  Excessive thirst  Cold extremities  
 Ankle swelling  Asthma  Other: \_\_\_\_\_

Do you have any forms of CANCER at this time? \_\_\_\_\_

Other Doctors Seen at this time:  MD  DC  DO  DDS Names: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Other Tests:  X-rays  MRI  CT  Blood Work  Urinalysis

Treatment: Medications: \_\_\_\_\_ Physiotherapy: \_\_\_\_\_ Other: \_\_\_\_\_

Results: \_\_\_\_\_ Length of time under care: \_\_\_\_ Yrs \_\_\_\_ Months - Frequency of Visits: \_\_\_\_\_

Are you currently taking any medications either prescribed or over the counter:  No  Yes: \_\_\_\_\_

**Do you have any medical insurance with chiropractic benefits that you want us to bill?  No  Yes,  
If yes we need to make a photo copy of your insurance card.**

**TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

Person or Persons Assisting Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you!! And again, we look forward to a healthy relationship with you.**