

Patient Case History

**HIPAA Protected Health Information
Authorized Access Only**

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Date _____ Patient/Clinic ID # _____

Name _____ Social Security # _____

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

Habits

Exercise

List region of pain and circle the severity number (1 = least, 10 = Greatest)

1) _____ 1 2 3 4 5 6 7 8 9 10 Smoking Packs/Day _____ None

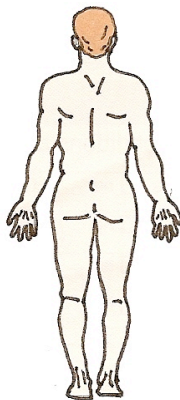
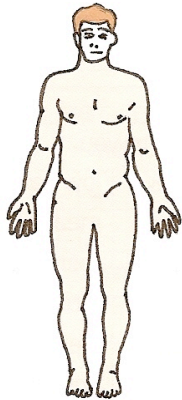
2) _____ 1 2 3 4 5 6 7 8 9 10 Alcohol Drinks/Day _____ Moderate

3) _____ 1 2 3 4 5 6 7 8 9 10 Coffee Cups/Day _____ Daily

4) _____ 1 2 3 4 5 6 7 8 9 10 Soda/Pop Cans/Day _____ Type _____

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 Scoliosis

Family History

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

Last Lab _____ Last Doctor's Name _____

Last X-ray _____ Medications _____

Last Advanced Imaging _____

Facility Location _____ Patient/Guardian signed Informed Consent _____

Last Pap Smear and Breast Exam _____ Notes _____

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.

GENERAL SYMPTOMS

- ___ 784.0 Headache
- ___ 780.6 Fever
- ___ 780.99 Chills
- ___ 780.8 Night Sweats
- ___ 780.2 Fainting
- ___ 780.4 Dizziness
- ___ 780.3 Convulsions
- ___ 780.52 Loss of Sleep
- ___ 780.7 Fatigue
- ___ 799.2 Nervousness
- ___ 783. Loss of Weight
- ___ 782. Numbness or pain
In arms/legs/hands
- ___ 995.3 Allergy _____
- ___ 786.07 Wheezing
- ___ 729.2 Neuralgia

GASTRO-INTESTINAL

- ___ 783.0 Poor Appetite
- ___ 536.8 Poor Digestion
- ___ 994.2 Starvation
- ___ 787.3 Belching or Gas
- ___ 787.0 Vomiting
- ___ 578.0 Vomiting Blood
- ___ 536.8 Pain over Stomach
- ___ 564.0 Constipation
- ___ 787.91 Diarrhea
- ___ 562.1 Colon Trouble
- ___ 455.6 Hemorrhoids (Piles)
- ___ 776.7 Fluid Retention
- ___ 873.9 Liver Trouble
- ___ 782.4 Jaundice
- ___ 575.9 Gall Bladder Trouble
- ___ 274. Gout

EYE/EAR/NOSE/THROAT

- ___ 368.9 Poor Vision
- ___ 378.0 Crossed Eyes
- ___ 379.91 Pain in Eyes
- ___ 389.9 Deafness
- ___ 388.70 Earache
- ___ 388.30 Ear Noises
- ___ 388.60 Ear Discharges
- ___ 478.1 Nasal Obstruction
- ___ 784.7 Nose Bleeds
- ___ 462. Sore Throats
- ___ 784.49 Hoarseness
- ___ 477.9 Hay Fever
- ___ 493.9 Asthma
- ___ 460. Frequent Colds
- ___ 240.9 Enlarged Thyroid
- ___ 473. Sinus Trouble

RESPIRATORY

- ___ 786.2 Chronic Cough
- ___ 786.3 Spitting Blood
- ___ 786.4 Spitting Phlegm
- ___ 786.50 Chest Pain
- ___ 786.09 Difficulty Breathing

GENITO-URINARY

- ___ 788.4 Frequent Urination
- ___ 788.1 Painful Urination
- ___ 590. Kidney Infection
- ___ 788.3 Bed Wetting
- ___ 788.3 Inability to Control Urine
- ___ 601.9 Prostate Trouble

MUSCLES & JOINTS

- ___ 728.9 Weakness
- ___ 781.0 Twitching
- ___ 723.5 Stiff Neck
- ___ 724.5 Backache
- ___ 719.0 Swollen Joints
- ___ 781. Tremors
- ___ 729.5 Foot Trouble
- ___ 724.79 Painful Tail bone
- ___ 724.5 Pain Between Shoulders
- ___ 737.3 Spinal Curvature

CARDIO-VASCULAR

- ___ 785.0 Rapid Heart
- ___ 427.89 Slow Heart
- ___ 401.9 High Blood Pressure
- ___ 458.9 Low Blood Pressure
- ___ 429.9 Heart Trouble
- ___ 719.07 Swelling Ankles
- ___ 459.9 Poor Circulation
- ___ 454.9 Varicose Veins
- ___ 436. Strokes
- ___ 785.1 Palpitations

SKIN OR ALLERGIES

- ___ 680. Skin Eruptions
- ___ 698.9 Itching
- ___ 924.9 Bruising Easily
- ___ 701.1 Dryness
- ___ 680.9 Boils
- ___ 782. Sensitive Skin
- ___ 708.9 Hives
- ___ 692.9 Eczema
- Notes _____

FOR WOMEN ONLY

- ___ 625.3 Painful Periods
- ___ 626.2 Excessive Flow
- ___ 626.4 Irregular Cycle
- ___ 627.5 Hot Flashes
- ___ 625.3 Cramps or Backaches
- ___ 623.5 Vaginal Discharge
- Are you pregnant? Yes No
- OBGYN _____
- Notes _____

IN PATIENT/OUT PATIENT OPERATIONS AND PROCEDURES

DATE	DATE	DATE	DATE
_____ Vaccinations	_____ Tonsillectomy	_____ Tubes in Ears	_____ Other
_____ Knee Surgery	_____ Shoulder	_____ Gall Bladder	_____ Other
_____ Back Surgery	_____ Sinus	_____ Appendectomy	_____ Other
_____ Thyroid	_____ Hernia	_____ Stomach	_____ Other
_____ Female	_____ Rectal	_____ Plastic Surgery	_____ Other

Other Procedures _____

Hospital Stays _____

List any accidents or falls with dates: Car _____ Recreational Vehicle _____ Sports _____
 School _____ Other _____

List any broken bones (fractures) or dislocations: _____

Have you ever been on crutches? Yes No _____

Have you ever had a lapse of memory? Yes No _____ Have you ever been unconscious? Yes No _____

Have you ever had x-rays taken? Yes No _____

Do you suffer from any other condition other than for which you are now consulting us? _____

Are you presently taking any medications – prescription or over-the-counter? Yes No _____

I understand and agree that health and accident insurance policies are 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 _____

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