

HAYES CHIROPRACTIC PATIENT CASE HISTORY

Name: _____ Today's date _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
Email Address: _____ Occupation: _____
Date of Birth: _____ Age _____ Social Security #: _____ - _____ - _____ Gender: Male - Female
Preferred Language _____ Smoking Status _____ Race/Ethnicity _____
Primary Care Physician _____
Were you referred? Yes No If yes, by whom? _____



Assignment of Benefits

I assign payment of all professional or medical expense benefits allowable and otherwise payable to me under my current Insurance policy to Hayes Chiropractic Center. _____ (signature)

List any **Allergies**:

Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen
 Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

List any **Surgeries**:

Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____

List **ALL Past Medical History** conditions:

Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression
 Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain
 Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure
 Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain
 Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's
 Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain
 Stroke/Heart Attack Other: _____

List Type of **Medications** you are taking:

Anxiety Muscle Relaxors Pain Killers Insulin Birth control Cardiovascular Allergy Seizure
 Other: _____ **Are you allergic to any medications:** No Yes

List your **Family History**:

Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition
 High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio
 Prostate Problems Stroke/Heart Attack Please list all family members who had/has any of the problems above:
Example: Grandmother – High blood pressure

Have you had any auto or other accidents? No Yes

Date of last physical examination: _____ Do you smoke? No Yes

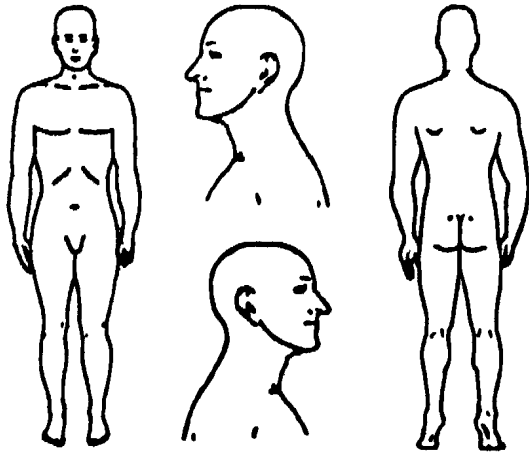
Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often):

Height _____ Weight _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Signature: _____