



## CASE HISTORY

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Age \_\_\_\_ Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex: Male Female Marital Status: M S D W # of children \_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell ( ) \_\_\_\_\_ - \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referred to our office by \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Nearest Relative or Friend \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Your Ins. Co. \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Coverage \_\_\_\_ % Deductible \$ \_\_\_\_\_

List your current complaints & symptoms: \_\_\_\_\_  
\_\_\_\_\_

When did you first notice these symptoms? \_\_\_\_\_ Have you had this before? Yes No

Are your symptoms: Improving / Getting worse / Staying about the same If female, are you pregnant? Yes No Possibly

Have you been examined/treated by another doctor for this? Yes No Type of doctor: DC MD DO ND LPN PA

Doctor's Name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Type of treatment \_\_\_\_\_ Were X-rays / MRI / CT Scan taken?

Length of time under his/her care \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Are you having any difficulty performing work or daily routines? Yes No If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

List medications you are currently taking: \_\_\_\_\_

List any medications you are allergic to: \_\_\_\_\_

Dates and description of any previous accidents or injuries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries (give date): \_\_\_\_\_

Broken bones (give date): \_\_\_\_\_

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**Circle any of the following symptoms you are currently having or have had in the past:**

Headache	Irritability / Difficulty sleeping	Fatigue / Weakness	Osteoporosis
Neck pain	Chest pain	Loss of balance	Arthritis
Neck stiffness	Shortness of breath	Fainting spells	Bursitis
Difficulty sleeping	Head feels heavy	Loss of taste / smell	High blood pressure
Low back pain	Numbness in arms / hands	Diarrhea / Constipation	Low blood pressure
Mid-back pain	Numbness in legs / feet	Difficulty remembering	Hypoglycemia
Upper back pain	Pain in arms / hands	ringing / Pressure in ears	Diabetes
Muscle spasms	Pain in legs / feet	Joint swelling / pain	Fibromyalgia
Dizziness / Vertigo	Artificial joint(s) Hip Knee ( right left )	Blurred vision / eye pain	Glaucoma / Cataracts
Heart trouble	Heart surgery (date): _____	Pacemaker	Asthma
Nervousness	Cold hands / feet	Nausea	Vomiting
Stroke	Epilepsy / Seizures	Migraine headaches	Cluster headaches
Depression	Anxiety / Panic attacks	Physical / Psychological abuse	Phobias
Anorexia / Bulimia	Unexplained weight loss	HIV / AIDS	Cancer
Alcoholism	Smoking ( ____ packs per day)	Emphysema	Chronic cough
Blood in stool / urine	Coughing or spitting up blood	Difficulty swallowing	Poor appetite
Hepatitis B C	Colitis	Anemia	Leukemia
Lupus	Infection: _____	Sinus problems	Allergies / Hay fever
Ulcers	Gallstones	Kidney problems / stones	Bladder problems
Frequent urination	Excessive thirst	Forgetfulness	Hearing loss
Hemorrhoids	Prostate trouble / cancer	Impotence	Hernia
Menstrual troubles	Breast lumps / cancer	Mastectomy: Left Right Both	Hot flashes
Hormone imbalance	Radiation therapy / Chemotherapy	Eczema / psoriasis	Tremor
Poor circulation	Swelling in ankles	Varicose veins	Multiple sclerosis
Any other symptoms: _____			
Family history of: Cancer Heart disease Heart attack Stroke Diabetes Other: _____			
If female, are you taking birth control pills? Yes No			

**I hereby affirm that the information I have given above is true and that I have not made any attempt to falsify my history nor misrepresent myself.**

**AUTHORIZATION FOR TREATMENT: I hereby authorize the doctor(s) and staff of The Spine Clinic to perform any necessary services or procedures deemed necessary to diagnose and treat my condition, and I agree to request an explanation of any procedure that I do not fully understand.**

**AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of information regarding my care at this office to my insurance company, my attorney, or any other entitled party.**

**AUTHORIZATION TO PAY BENEFITS: I hereby authorize direct payment to The Spine Clinic any benefits due me under any insurance policy or claim settlement as far as is necessary to cover my treatment. I understand that I am personally responsible for my bill and hereby agree to pay any amount not covered by a third party.**

Signature \_\_\_\_\_ Date \_\_\_\_\_