



Prime Health

Family & Sports Chiropractic Wellness Center



Patient Case History

Date _____ Name _____

Case # _____ Patient I.D. # _____ Driver's License # _____

Social Security # _____ Address _____

City _____ State _____ Zip _____ Home Phone(_____) _____

Cell Phone(_____) _____ Email _____

Insurance Carrier _____ Insurance Group ID # _____

Sex M F Age _____ Date of Birth _____ Single Married Widowed Separated Divorced

Occupation _____ Employer Work Phone(_____) _____

Work Address _____ Years Worked _____

Spouse _____ List Children _____

Spouse's Social Security _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone(_____) _____ Ext. _____

Spouse's Insurance Carrier _____ Spouse's Insurance Group ID # _____

Primary Physician Name _____ Medications Currently Taking _____

List Surgeries and Results _____

Are your present problems due to an injury? Yes No On the Job Auto Collision Personal Injury Other

Have you made a report of your accident? Yes No To Employer Auto Carrier Other

Has the accident been reported? Yes No Workers Comp Auto Carrier Other

Are you now or have you ever been disabled/impaired? (Service or Work?) Yes No When _____

Have you retained an attorney? Yes No Name & Address _____

Chief Complaint/Spinal Regions of Pain

- 1) Neck _____
- 2) Back _____
- 3) Hips _____
- 4) Arms/Hands _____
- 5) Legs/Feet _____

Habits

- Smoking Packs/Day _____
- Alcohol Cups/Day _____
- Coffee Cups/Day _____
- Soda Cups/Day _____

Exercise

- None
- Moderate
- Daily
- Type _____

Severity of Pain

List region of pain and circle severity number. (1 = less, 10 = greatest)

Regions

- 1) Neck

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----
- 2) Mid Back

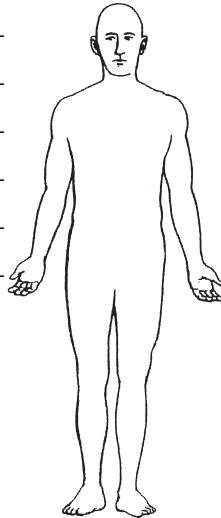
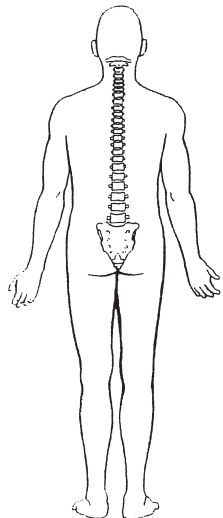
1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----
- 3) Low Back

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----
- 4) Hip

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----
- 5) Arms/Hands

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----
- 6) Legs/Feet

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----



Mark Pain Area on Figures Using Code

- +++ Burning
- 000 Stabbing
- Sharp
- /// Constant
- xxx Other

Have you had any of the following diseases?

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Sprain/Strain Sacroiliac |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Whiplash |

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother - Living <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father - Living <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adoption History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OFFICE USE ONLY

Patient's Last Physical _____

Patient's Last Lab _____

Patient's Last X-ray _____

Patient's Prostate Exam _____

Patient's Last Pap Smear _____

Patient's Last Breast Exam _____

Patient's Last Spinal Exam _____

Patient's Last Spinal X-ray _____

Patient's Last EMG _____

Patient's Last Infrared Thermography _____

Patient's Last Disc Exam _____

Patient's Last MRI _____

Patient's Last CT Scan _____

Notes _____

Please enter: NA if Not Applicable; "1" Previously; "2" Presently; in front of the following signs and symptoms. Behind condition, put the number of times per month condition occurs.

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
- ___ 783.0 Loss of Weight
- ___ 782.0 Numbness or Pain in arms/legs/hands
- ___ 995.3 Allergy (What)
- ___ 786.07 Wheezing
- ___ 729.2 Neuralgia
- ___ 728.9 Weakness
- ___ 781.0 Twitching
- ___ 723.5 Stiff Neck
- ___ 724.5 Backache
- ___ 719.0 Swollen Joints
- ___ 781.0 Tremors
- ___ 729.5 Foot Trouble
- ___ 724.79 Painful Tail Bone
- ___ 724.5 Pain Between Shoulders
- ___ 737.3 Spinal Curvature

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
- ___ 274.0 Gout
- ___ 782.4 Jaundice
- ___ 575.9 Gall Bladder Trouble
- ___ 785.0 Rapid Heart
- ___ 427.89 Slow Heart
- ___ 401.9 High Blood Pressure
- ___ 458.9 Low Blood Pressure
- ___ 786.51 Pain Over Heart
- ___ 429.9 Heart Trouble
- ___ 719.07 Swelling Ankles
- ___ 459.9 Poor Circulation
- ___ 454.9 Varicose Veins
- ___ 436.0 Strokes
- ___ 785.1 Palpitations

Eye/Ear/Nose/Throat

- ___ 368.9 Poor Vision
- ___ 378.0 Crossed Eyes
- ___ 379.91 Pain in Eyes
- ___ 389.9 Deafness
- ___ 388.7 Earache
- ___ 388.3 Ear Noise
- ___ 388.6 Ear Discharge
- ___ 478.1 Nasal Obstruction
- ___ 784.7 Nose Bleeds
- ___ 462.0 Sore Throats
- ___ 784.49 Hoarseness
- ___ 477.9 Hay Fever
- ___ 493.9 Asthma
- ___ 460.0 Frequent Colds
- ___ 240.9 Enlarged Thyroid
- ___ 463.0 Tonsillitis
- ___ 473.0 Sinus Troubles
- ___ 680.0 Skin Eruptions – No
- ___ 698.9 Itching
- ___ 924.9 Bruising Easily
- ___ 701.1 Dryness
- ___ 680.9 Boils
- ___ 782.0 Sensitive Skin
- ___ 708.9 Hives or Allergy
- ___ 692.9 Eczema

Medicines _____

Respiratory

- ___ 786.2 Chronic Cough
- ___ 786.3 Spitting Blood
- ___ 786.4 Spitting Phlegm
- ___ 786.5 Chest Pain
- ___ 786.09 Difficulty Breathing

Genito-Urinary

- ___ 788.4 Frequent Urination
- ___ 788.1 Painful Urination
- ___ 599.7 Blood in Urine
- ___ 590.0 Kidney Infection
- ___ 788.3 Bed Wetting
- ___ 788.3 Inability to control Urine
- ___ 601.9 Prostate Trouble

For Women Only

- ___ 625.3 Painful Periods
- ___ 626.2 Excessive Flow
- ___ 626.4 Irregular Cycle
- ___ 627.2 Hot Flashes
- ___ 625.3 Cramps or Backaches
- ___ 623.5 Vaginal Discharge
- ___ Pregnant at this Time
- ___ Last Pap

By Whom _____
 Other _____

In Patient / Out Patient Operations and Procedures - Hospitalization

Date _____	Date _____	Date _____	Date _____
_____ Vaccinations	_____ Tubes in Ears	_____ Sinus	_____ Other
_____ Tonsillectomy	_____ Appendectomy	_____ Hernia	_____ Other
_____ Gall Bladder	_____ Female Organs	_____ Thyroid	_____ Other
_____ Back Operation	_____ Rectal Surgery	_____ Stomach	_____ Other

Hospitals Stays _____

Have you ever had any accidents or falls of any kind? List dates: Car _____ Recreational Vehicle _____

Sports _____ School _____ Other _____

List any broken bones (fractures) or dislocations: _____

Have you ever been on crutches? Yes No Why? _____

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

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were those X-rays made? _____ Do you suffer from any condition other than that for which you are now

consulting us? _____

Are you presently taking any medication – prescription or over-the-counter? Yes No If Yes, please list: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will 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 I 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/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives 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 he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file and x-rays upon request. Copying fees may apply.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Doctor Signature _____ Date _____