CASE HISTORY

PLEASE PRINT!

Name ____________________
Address ____________________
City __________ State __________ Zip ______
Telephone __________ Alt # __________
Social Security # __________
Age ______ Birth Date __________
Sex M F Marital Status M S W D
Children ______

Please Fill Out Completely

Occupation __________ Employer __________ Location __________
Spouse's name __________ Occupation __________ Emergency Contact __________

—How did you find out about our office?—

❑ Referred by person __________ ❑ Advertisement ❑ Yellow Pages

What is your *main complaint?* ____________________

Other complaints or health problems

How long have you had this condition? __________

Have you had this or a similar condition in the past? ❑ *YES* ❑ *NO*

What activities aggravate your condition?

Is this condition getting progressively worse? ❑ *YES* ❑ *NO*

Is this condition interfering with your ❑ *Work* ❑ *Sleep* ❑ *Daily Routine* ❑ *Other*

How long has it been since you really felt good? __________

List all surgical procedures or fractures.

Are you taking any prescription *or* nonprescription *medication?* ❑ *YES* ❑ *NO*

What kind? __________

Other doctors seen for this condition:

Chiropractor Medical Doctor Osteopath Dentist Alternative

Length of time under care ______ *Were your results* ❑ *Good* ❑ *Fair* ❑ *Poor (comment):*

Is this an active work injury? ❑ *YES* ❑ *No / An active auto accident injury?* ❑ *YES* ❑ *NO*

I have filled out this history form as accurately as possible. I recognize that I AM SOLELY RESPONSIBLE FOR PAYMENT of services rendered.

Patient's Signature ____________________ DATE

Parent's Signature if minor ____________________

Please complete back of page!

Please check ALL items that may pertain to you:

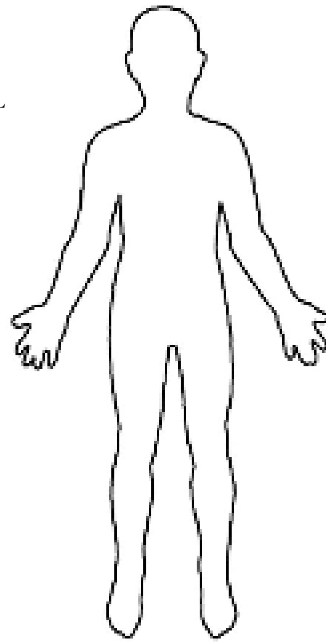
NECK
- ❑Neck pain
- ❑Neck pain with movement:
  - —Forward
  - —Backward
  - —Turn to left
  - —Turn to right
  - —Bend left
  - —Bend right
- ❑"Pinched" nerve
- ❑Feels out of place
- ❑Muscle spasms
- ❑Grinding sounds
- ❑Popping sounds

HEAD
- ❑Headache:
  - —Sinus
  - —Entire head
  - —Back of head
  - —Forehead
  - —Temples
  - —Migraine
- ❑Head feels heavy
- ❑Loss of memory
- ❑Light headedness
- ❑Fainting
- ❑Light bothers eyes
- ❑Blurred vision
- ❑Double vision
- ❑Loss of vision
- ❑Loss of taste
- ❑Loss of balance
- ❑Dizziness
- ❑Loss of hearing
- ❑Pain in ears
- ❑Ringing in ears
- ❑Buzzing in ears

ARMS & HANDS
- ❑Pain in upper arm
- ❑Pain in elbow
- ❑Aggravated by movement
- ❑Tennis elbow
- ❑Pain in forearm
- ❑Pain in hands
- ❑Pain in fingers
- ❑Pins and needles in arms
- ❑Pins and needles in hands
- ❑Numbness in arms R / L
- ❑Numbness in fingers R / L
- ❑Fingers go to sleep
- ❑Hands cold
- ❑Swollen joints in fingers
- ❑Sore joints and fingers
- ❑Arthritis in fingers
- ❑Loss of grip strength

CHEST
- ❑Chest pain
- ❑Shortness of breath
- ❑Pain around ribs
- ❑Breast pain
- ❑Dimpled /orange peel breast
- ❑Irregular heatbeat

SHOULDERS
- ❑Shoulder joint pain R / L
- ❑Pain across shoulders
- ❑Tension
- ❑Muscle spasms
- ❑Bursitis
- ❑Pain between shoulders
- ❑Can't raise arm
  - —Above shoulder level
  - —Over head
  - —Around back



MID-BACK
- ❑Mid-back pain
- ❑Pain between shoulder blades
- ❑Sharp stabbing
- ❑Dull ache
- ❑Pain from front to back
- ❑Muscle spasms
- ❑Pain in kidney areas

GENERAL
- ❑Nervousness
- ❑Irritable
- ❑Depressed
- ❑Fatigue
- ❑Generally feel run-down
- ❑Loss of sleep——hrs/night
- ❑Loss of weight ——lbs.
- ❑Weight gain——lbs.
- ❑Coffee——cups/day
- ❑Tea——cups/day
- ❑Cigarettes——packs/day
- ❑Other
- ❑Diabetes
- ❑Hypoglycemia

ABDOMEN
- ❑Nervous stomach
- ❑Foods can't eat
- ❑Nausea
- ❑Gas
- ❑Constipation
- ❑Diarrhea
- ❑Hemorrhoids

FEMALE ONLY
- ❑Menstrual pain (where?)
- ❑Cramping
- ❑Irregularity
- ❑Hysterectomy
- ❑Genital cancer
- ❑Discharge
- ❑Tumors
- ❑Menopause

MEN ONLY
- ❑Urinary frequency
- ❑Difficulty in starting
- ❑Night urination
- ❑Prostate pain/swelling

HIPS/LEGS/FEET
- ❑Pain in buttocks R / L
- ❑Pain in hip joint R / L
- ❑Pain down leg R / L
- ❑Pain down both legs
- ❑Knee pain
  - —Inside
  - —Outside
- ❑Leg cramps
- ❑Cramps in feet R / L
- ❑Pins and needles in legs R / L
- ❑Numbness of legs
- ❑Numbness of feet
- ❑Numbness of toes
- ❑Feet feel cold
- ❑Swollen ankles R / L
- ❑Swollen fee R / L

LOW BACK
- ❑Low back pain:
  - —Upper lumbar
  - —Lower lumbar
  - —Sacroilliac
- ❑Low back pain is worse when:
  - —Working
  - —Lifting
  - —Stooping
  - —Standing
  - —Sitting
  - —Bending
  - —Coughing
  - —Lying down (sleeping)
  - —Walking
- ❑Pain relieves when————————
- ❑Disc problems
- ❑Low back feels out of place
- ❑Muscle spasms

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HIGHLAND CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction os by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment or locking of one or more of the vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition. We only analyze, diagnose and adjust vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____(signature)___________________(date)

• RECORDS

I hereby grant permission for Highland Chiropractic / Jeffrey Hunt, DC to release any records, reports, x-rays, histories or account information from my patient file with any attorney, hospital, insurance company, chiropractor or physician upon their request.

______________________________________(sign)____________(date)_________(witness)

• VIDEOFLOUROSCOPY

Due to technical factors beyond our control, we are unable to reproduce images from videoflouroscopy (video x-ray) studies for other entities. Thank you for your understanding with this matter.