Drees Family & Sports Chiropractic

CASE HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **Thank you**

(Please Print)

Date____

Name_______________________________________

Address_____________________________________

City____________________State______Zip________

Home Phone__________________________________

Email Address________________________________

Patient SS#____________________Male__Female__

Birth date____/____/____ Marital Status S M W

Occupation___________________________________

Employer____________________________________

Work Phone__________________________________

Spouse's Name_______________________________

Spouse's Birth date___________________________

Spouse's Employer____________________________

Referred by__________________________________

Accident Information

Is condition due to an accident? __Yes __No

Type of accident __Auto __Work __Home __Other

To whom have you made a report of your accident?

__Auto Insurance __Employer __Other __None

Attorney Name (if applicable)____________________

____

Describe present complaints and symptoms__________

____

____

____

____

Describe the pain: Constant Intermittent Local Radiating

Rate the intensity: (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

What makes the pain better? ________________________

What makes the pain worse? ________________________

Is the pain progressively getting worse? ______________

Date you first noticed Symptoms? ___/___/___

Has this happened before? __No __Yes When?__________

Pain Diagram:

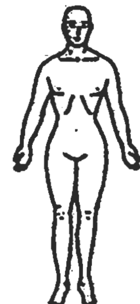
__Sharp

__Dull

__Stabbing

__Burning

__Tingling



Have you Ever:

Been knocked unconscious?	__Yes	__No
Used a crutch or other support?	__Yes	__No
Been treated for a spine or nerve disorder?	__Yes	__No
Had a fractured bone?	__Yes	__No
Had surgery?	__Yes	__No
Been hospitalized for other than surgery?	__Yes	__No
Had any mental or emotional disorders?	__Yes	__No

Been in an auto accident? __Never __Past year __Past 5 years __Over 5 years

Had a personal injury? __Never __Past year __Past 5 years __Over 5 years

Please check the appropriate box for any of the following symptoms you have or have had or been diagnosed with previously. We want all the facts about your health before we accept your case. **This is a Confidential Health Report.**

Muscle & Joint

__Arthritis
__Bursitis
__Foot Trouble
__Low Back Pain
__Neck Pain or Stiffness
__Pain between Shoulders

Pain or Numbness in:

__Shoulders
__Arms
__Elbows
__Hands
__Hips
__Legs
__Knees
__Feet
__Swollen Joints

Conditions

__Alcoholism
__Anemia
__Appendicitis
__Cancer
__Diabetes
__Eczema
__Emphysema
__Goiter
__Gout
__Heart Disease
__Miscarriage
__Multiple Sclerosis
__Polio
__Rheumatic Fever
__Stroke
__Tuberculosis
__Ulcers

Respiratory

__Chest Pain
__Chronic Cough
__Difficult Breathing
__Spitting up Blood
__Spitting up Phlegm
__Wheezing

Gastro-Intestinal

__Colon Trouble
__Gall Bladder Trouble
__Hemorrhoids
__Liver Trouble
__Pain Over Stomach

Genito-Urinary

__Bed-wetting
__Blood in Urine
__Frequent Urination
__Kidney Infection
__Kidney Stones
__Painful Urination

Cardio-Vascular

__Hardening of Arteries
__High Blood Pressure
__Low Blood Pressure
__Pain Over Heart
__Poor Circulation
__Rapid Heartbeat
__Slow Heartbeat
__Swelling of Ankles

General

__Allergy
__Convulsions
__Dizziness
__Fainting
__Headache
__Numbness

EENT

__Asthma
__Colds
__Earaches
__Ear Noises
__Eye Pain
__Sore Throat
__Nose Bleeds
__Sinus Infection

Do You Use:

Alcohol __Yes __No
Coffee __Yes __No
Tobacco __Yes __No
Exercise __Yes __No
Medications __Yes __No
Medication you now take:
____
____

Date of Last:

Spinal Exam ___/___/___
Physical Exam ___/___/___
X-rays ___/___/___
Lab Tests ___/___/___

For Women Only:

__Congested Breasts
__Cramps or Backache
__Excessive Menstrual Flow
__Hot Flashes
__Irregular Cycle
__Lumps in Breast
__Menopausal Symptoms
__Painful Menstruation
__Vaginal Discharge

Assignment and Release

I, the undersigned, certify that I (or my covered dependent) have insurance with ______________________________ and assign directly to Drees Family & Sports Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all non-covered charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions until a date in which I wish to remove it by contacting the office in writing.

Signature_________________________ Date___/___/___

To the best of my knowledge, all information I have given is accurate and I have read the case history questions entirely.

Signature____ Date___/___/___