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/ Cell_____

___Male ___Female Soc. Sec. #_____ Birth date_____/_____/_____ Marital Status S M W

Occupation_____ Employer_____

Work Phone_____ Email Address_____

Spouse's Name_____ Spouse's Employer_____

Referred by:_____ Describe present complaints and symptoms _____

_____

Is condition due to an accident? __Yes __No If so, Type of Accident: __Auto __Work __Home __Other

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?_____ Have you had Chiropractic care before? ___Yes ___No

If you've had Chiropractic care before, when were you last seen by a chiropractor? _____

Pain Diagram- Please circle area(s) of pain:

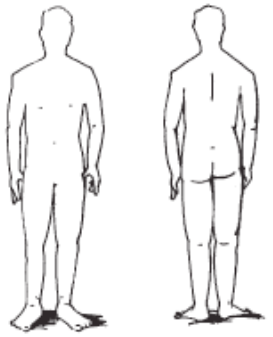
__Sharp

__Dull

__Stabbing

__Burning

__Tingling

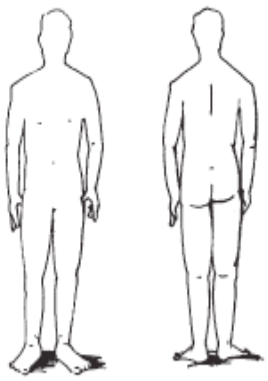


Front **Back**

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

For Doctor's Use Only:



Drs. Notes: _____

_____

_____

_____

_____

_____

Please check Yes or No for 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 __Yes __No
Bursitis __Yes __No
Low Back Pain __Yes __No
Foot Trouble __Yes __No
Neck Pain or Stiffness __Yes __No
Pain Between Shoulders __Yes __No
Swollen Joints __Yes __No

Pain or Numbness in:

Shoulders __Yes __No
Arms __Yes __No
Elbows __Yes __No
Hands __Yes __No
Hips __Yes __No
Legs __Yes __No
Knees __Yes __No

Eyes, Ears, Nose, Throat:

Asthma __Yes __No
Colds __Yes __No
Earaches __Yes __No
Eye Pain __Yes __No
Sore Throat __Yes __No
Nose Bleeds __Yes __No
Sinus Infection __Yes __No

Genito-Urinary:

Bed Wetting __Yes __No
Blood in Urine __Yes __No
Frequent Urination __Yes __No
Kidney Infection __Yes __No
Painful Urination __Yes __No

Gastro-Intestinal:

Colon Trouble __Yes __No
Hemorrhoids __Yes __No
Liver Trouble __Yes __No
Gall Bladder Trouble __Yes __No
Pain Over Stomach __Yes __No

Conditions:

Alcoholism __Yes __No
Anemia __Yes __No
Appendicitis __Yes __No
Cancer __Yes __No
Diabetes __Yes __No
Eczema __Yes __No
Emphysema __Yes __No
Goiter __Yes __No
Heart Disease __Yes __No
Gout __Yes __No
Miscarriage __Yes __No
Polio __Yes __No
Rheumatic Fever __Yes __No
Stroke __Yes __No
Tuberculosis __Yes __No
Ulcers __Yes __No
Multiple Sclerosis __Yes __No

Cardio-Vascular:

Hardening of Arteries __Yes __No
High Blood Pressure __Yes __No
Low Blood Pressure __Yes __No
High Cholesterol __Yes __No
Pain Over Heart __Yes __No
Poor Circulation __Yes __No
Rapid Heartbeat __Yes __No
Slow Heartbeat __Yes __No
Swelling of Ankles __Yes __No

General:

Allergy __Yes __No
Convulsions __Yes __No
Dizziness __Yes __No
Fainting __Yes __No
Headache __Yes __No
Numbness __Yes __No

For Women Only:

Congested Breasts __Yes __No
Excessive Menstrual Flow __Yes __No
Lumps in Breast __Yes __No
Cramps or Backache __Yes __No
Menopausal Symptoms __Yes __No
Painful Menstruation __Yes __No
Irregular Cycle __Yes __No
Hot Flashes __Yes __No
Vaginal Discharge __Yes __No

Respiratory:

Chest Pain __Yes __No
Chronic Cough __Yes __No
Difficult Breathing __Yes __No
Spitting up Blood __Yes __No
Spitting up Phlegm __Yes __No
Wheezing __Yes __No

Date of Last:

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

Other Medical Conditions Not Listed Above:

_____
_____
_____

Medications you now take:

_____
_____
_____

Do You Use:

Alcohol __Yes __No
Coffee __Yes __No
Tobacco __Yes __No
Exercise __Yes __No

Insurance 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___/___/___