HAYES CHIROPRACTIC PATIENT CASE HISTORY

Name: _____ Today's date_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Age_____ Social Security #: _____-_____-_____ Gender: Male - Female

Preferred Language_____ Smoking Status_____ Race/Ethnicity_____

Primary Care Physician_____

Were you referred? O Yes O No If yes, by whom? _____

Assignment of Benefits

I assign payment of all professional or medical expense benefits allowable and otherwise payable to me under my current Insurance policy to Hayes Chiropractic Center. _____ **(signature)**

List any **Allergies**:

O Animals O Aspirin O Bees O Chocolate O Dairy O Dust O Eggs O Latex O Molds O Penicillin O Ragweed/Pollen O Rubber O Seasonal Allergies O Shellfish O Soaps O Wheat O X-Ray Dye O Other: _____

List any **Surgeries**:

O Back O Brain O Elbow O Foot O Hip O Knee O Neck O Neurological O Shoulder O Wrist O Other: _____

List **ALL Past Medical History** conditions:

O Ankle Pain O Arm Pain O Arthritis O Asthma O Back Pain O Broken Bones O Cancer O Chest Pain O Depression O Diabetes O Dizziness O Elbow Pain O Epilepsy O Eye/Vision Problems O Fainting O Fatigue O Foot Pain O Genetic Spinal Condition O Hand Pain O Headaches O Hearing Problems O Hepatitis O High Blood Pressure O Hip Pain O HIV O Jaw Pain O Joint Stiffness O Knee Pain O Leg Pain O Menstrual Problems O Mid-Back Pain O Minor Heart Problem O Multiple Sclerosis O Neck Pain O Neurological Problems O Pacemaker O Parkinson's O Polio O Prostate Problems O Shoulder Pain O Significant Weight Change O Spinal Cord Injury O Sprain/Strain O Stroke/Heart Attack O Other: _____

List Type of **Medications** you are taking:

O Anxiety O Muscle Relaxors O Pain Killers O Insulin O Birth control O Cardiovascular O Allergy O Seizure O Other: _____ **Are you allergic to any medications:** O No O Yes

List your **Family History**:

O Arthritis O Asthma O Back Pain O Cancer O Depression O Diabetes O Epilepsy O Genetic Spinal Condition O High Blood Pressure O Heart Problems O Multiple Sclerosis O Neurological Problems O Parkinson's O Polio O Prostate Problems O Stroke/Heart Attack O Please list all family members who had/has any of the problems above:

Example: Grandmother – High blood pressure

_____

Have you had any auto or other accidents? O No O Yes

Date of last physical examination: _____ Do you smoke? O No zYes

Do you drink alcohol? O No O Yes - how many per day? _____

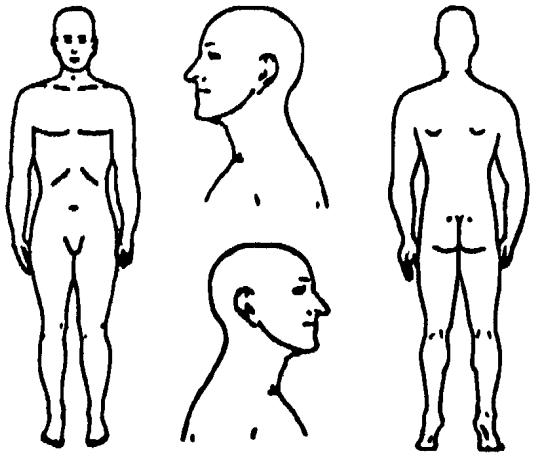
Do you drink caffeine? O No O Yes - how many per day? _____

Do you exercise? O No O Yes (what forms and how often):

_____

Height_____ Weight_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- O Become pain free
- O Explanation of my condition
- O Learn how to care for my condition
- O Reduce symptoms
- O Resume normal activity level

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? O GETTING BETTER O GETTING WORSE O NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

O Constantly (76-100% of the day) O Frequently (51-75% of the day)

O Occasionally (26-50% of the day) O Intermittently (0-25% of the day)

Describe the nature of your symptoms: O Sharp O Dull O Numb O Burning O Shooting O Tingling O Radiating Pain

O Tightness O Stabbing O Throbbing O Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

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

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Signature: _____