WALSH CHIROPRACTIC

CASE HISTORY

Name_____ Date_____

Address_____City_____State_____ Zip code_____

Telephone: (Home) _____ (Cell) _____ (Work) _____

Email _____ SS#_____-_____-_____

Age_____ Birthdate_____/_____/_____ Sex: M/F Status: M S W D No. of Children_____

Occupation_____Employer_____Address_____

Spouse's Name_____ Occupation_____

Person responsible for this account: Self/Spouse/Parent Referred by_____

What is your major complaint? _____

_____

Other complaints_____ How long have you had this condition? _____

Have you had this or similar conditions in the past? Yes ☐ No ☐ Explain:_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other: _____

How long has it been since you felt really good? _____List surgical operations: _____

Are you taking any medications? _____ What kind? _____

Any non-prescription drugs? _____ What kind? _____

Other doctors seen for this condition: MD ☐ DC ☐ DO ☐ Other _____

ACCIDENT INFORMATION:

Did your accident occur while at work? Yes ☐ No ☐ Were you involved in an auto accident? Yes ☐ No ☐

Date_____ Time_____ Injury reported to employer? _____ Name of Supervisor_____

Description of Accident _____

Were you injured? _____ Were you hospitalized? _____ Where? _____ How long? _____

Have you had any other personal injury or accident? _____ When? _____

Do you have an attorney? Yes ☐ No ☐ Name & Address_____

Are you interested in: ☐ Relief Care ☐ Corrective Care? Do you want the doctor to choose for you? ☐ Yes ☐ No

I understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I decide to terminate my care and treatment, any fees or services rendered to me will be immediately due and payable.

Patient's Signature_____ Date_____

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www.walshchiropractic.com

PLEASE CHECK ALL PRESENT SYMPTOMS

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

NECK:
- ☐ Pain
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Tension in shoulders
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Upper arm pain
- ☐ Elbow pain
- ☐ Movement increases pain
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Tingling in arms (R—L)
- ☐ Tingling in fingers (R—L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Joints swollen in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp, stabbing pain
- ☐ Dull, achy pain
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Rib pain
- ☐ Heartburn
- ☐ Shortness of breath
- ☐ Pain upon inspiration

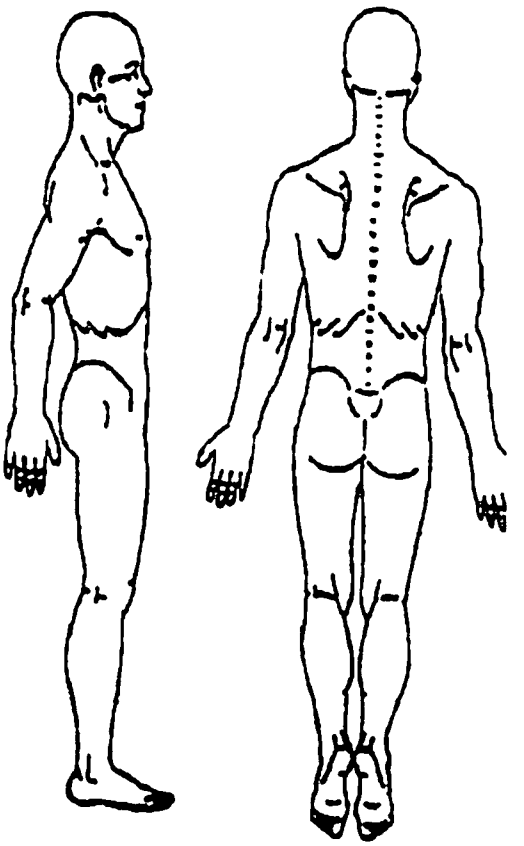
ABDOMEN:
- ☐ Upset stomach
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Pain after eating

LOW BACK:
- ☐ Low back pain
- ☐ Low back pain worse when:
  - ☐ bending
  - ☐ lifting
  - ☐ twisting
  - ☐ walking
  - ☐ sitting
  - ☐ standing
  - ☐ coughing
  - ☐ sleeping
- ☐ Muscle spasms

HIPS, LEGS, & FEET:
- ☐ Pain in hip joint (R—L)
- ☐ Pain in buttocks (R—L)
- ☐ Pain down leg (R—L)
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Numbness of leg (R—L)
- ☐ Numbness of feet (R—L)
- ☐ Numbness of toes

GENERAL:
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Loss of sleep
- ☐ Loss of weight_____lbs
- ☐ Gain of weight_____lbs
- ☐ Diabetes
- ☐ Other_____

CIRCLE AREA(S) OF COMPLAINT ON THE BODY DIAGRAM BELOW:



DOCTOR'S REMARKS:

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