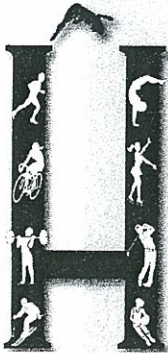


Higher Health Chiropractic and Rehabilitation

Patient Case History

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Full Name _____ Date _____
 Address _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Cell Phone _____
 Email _____ Date of Birth _____ Sex M F
 Drivers License # _____ Social Security # _____
 Occupation _____ Single Married Widowed Divorced
 Name of Primary Care Physician _____
 List Medications _____
 List Surgeries _____
 List Post Operative Care _____

Are your present problems due to an injury? Yes No On the Job Auto Collision Personal Injury Other
 Have you made a report of your accident? Yes No To Employer Auto carrier Other _____
 Has the accident been reported? Yes No Workman's Comp Auto carrier Other _____
 Have you now or have you ever been disabled/impaired? (Service or Work?) Yes No When _____
 Have you retained an attorney? Yes No Name and Address _____

Chief Complaint/ Spinal Regions of Pain

1. Neck _____
2. Back _____
3. Hips _____
4. Arms/Hands _____
5. Legs/Feet _____

Habits

Smoking Packs per day _____
 Alcohol Cups per day _____
 Coffee Cups per day _____
 Soda Cups per day _____

Exercise

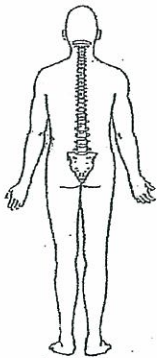
None
 Moderate
 Daily
 Type _____

Severity of Pain
 List region of pain and circle severity (1=least 10=Greatest)

Mark Pain Region
 Burning • Stabbing • Sharp • Constant
 Example: Neck _____ Sharp _____
 1 2 3 4 5 6 7 8 9 10

Have you had any of the following Diseases

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rheumatic
Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Mental Disorder | |



Mark Pain Area

Neck _____
 1 2 3 4 5 6 7 8 9 10

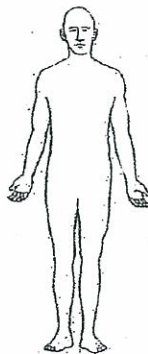
Mid-Back _____
 1 2 3 4 5 6 7 8 9 10

Low Back _____
 1 2 3 4 5 6 7 8 9 10

Hips _____
 1 2 3 4 5 6 7 8 9 10

Arms/Hands _____
 1 2 3 4 5 6 7 8 9 10

Legs/Feet _____
 1 2 3 4 5 6 7 8 9 10



Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adoption History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Check All That Apply.

<p>All Symptoms</p> <input type="checkbox"/> Headache <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Convulsions <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Fatigue <input type="checkbox"/> Nervousness <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Numbness or pain in arms/legs/hands <input type="checkbox"/> Allergy <input type="checkbox"/> Wheezing <input type="checkbox"/> Neuralgia <p>Muscles & Joints</p> <input type="checkbox"/> Weakness <input type="checkbox"/> Twitching <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Back ache <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Tremors <input type="checkbox"/> Foot Trouble <input type="checkbox"/> Painful Tail Bone <input type="checkbox"/> Pain between Shoulders <input type="checkbox"/> Spinal Curvature	<p>Gastro-Intestinal</p> <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Poor Digestion <input type="checkbox"/> Starvation <input type="checkbox"/> Belching or Gas <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Pain Over Stomach <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Colon Trouble <input type="checkbox"/> Hemorrhoids (Piles) <input type="checkbox"/> Fluid Retention <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Gout <input type="checkbox"/> Jaundice <input type="checkbox"/> Gall Bladder Trouble <p>Cardio-Vascular</p> <input type="checkbox"/> Rapid Heart <input type="checkbox"/> Slow Heart <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Pain over Heart <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Swelling Ankles <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Strokes	<p>Eye/Ear/Nose/Throat</p> <input type="checkbox"/> Poor Vision <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Pain in Eyes <input type="checkbox"/> Deafness <input type="checkbox"/> Earache <input type="checkbox"/> Ear Noises <input type="checkbox"/> Ear Discharges <input type="checkbox"/> Nasal Obstruction <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sore Throats <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hay Fever <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Enlarged Thyroid <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Sinus Trouble <p>Skin or Allergies</p> <input type="checkbox"/> Skin Eruptions <input type="checkbox"/> Itching <input type="checkbox"/> Bruising Easily <input type="checkbox"/> Dryness <input type="checkbox"/> Boils <input type="checkbox"/> Sensitive Skin <input type="checkbox"/> Hives or Allergies <input type="checkbox"/> Eczema <input type="checkbox"/> Medicines	<p>Respiratory</p> <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Spitting Blood <input type="checkbox"/> Spitting Phlegm <input type="checkbox"/> Chest Pain <input type="checkbox"/> Difficulty Breathing <p>Genito-Urinary</p> <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Inability to control Urine <input type="checkbox"/> Prostate Trouble <p>For Women Only</p> <input type="checkbox"/> Painful Periods <input type="checkbox"/> Excessive Flow <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Cramps or Backaches <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Pregnant at this time <input type="checkbox"/> Last Pap By whom _____ <input type="checkbox"/> Other _____ _____ _____
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In Patient/ Out Patient operations and Procedures - Hospitalization

<p>Date</p> _____ Vaccinations _____ Tonsillectomy _____ Gall Bladder _____ Back Operation	<p>Date</p> _____ Stomach _____ Tubes in Ears _____ Appendectomy _____ Female Organs	<p>Date</p> _____ Rectal Surgery _____ Thyroid _____ Sinus Surgery _____ Hernia _____ Other
--	--	--

Hospital Stays _____

Other Surgeries _____

List any accidents or Falls and List Dates Car _____ Recreational Vehicle _____

Sports _____ School _____ Other _____

List any Broken Bones or Dislocations _____

Have you ever been on crutches Yes No When _____

Have you ever had a lapse of memory? Yes No Have you ever been unconscious? Yes No

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or over the counter Yes No List _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctors office will be credited to my account on receipt. However I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I hear by authorize the Doctor to examine and treat my condition as she deems appropriate though the use of Chiropractic Health Care and I give authority for these procedures to be preformed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time I am a active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file and X-rays upon request. Copying fees may apply.

Patient Signature