Patient Case History
Helping Hands Chiropractic

Date ________________________________
Id # ________________________ Drivers License # ________________________________
Name________________________ Social Security# ________________________________
Address___________________________________ City____________________ State_____
Zip Code ___________________
Home Phone_________________ Cell Phone_______________ Email ________________
Insurance Co. ______________________________ Insurance Phone _________________
Sex ☐ M ☐ F Age ____ Date of Birth ______
☐Single ☐married ☐ Widowed ☐ ☐Separated ☐Divorced
Occupation: _________________________
Employer ___________________________ Work Phone _______________ Ext._________
Work Address _______________________ Years Worked _____________________________
Spouse ____________________________ Children _________________________________
Spouses SS# ______________________ Spouses Occupation_______________________
Spouses Employer ______________________Spouses Work Phone _________________
Spouses Insurance _______________________ Spouse's D/O/B _______________________
Primary Care Physician ______________________ Last Visit __________________________
List Medications____
Care Received ___________________________ List Surgeries _______________________
Results ____
Any other physician sought for this complaint___________________________________

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 ☐Workers Comp ☐ Auto Carrier ☐ Other__________
Are you now or have you ever been disabled/impaired? (Service or work) ☐Yes ☐No
When _______________________
Have you retained an attorney? ☐ yes ☐No
If So Name ____

Address:____

Chief Complaint/ Spinal Regions of Pain
1. Neck
____
2. Back
____
3. Hips
____
4. Arms /Hands
____
5. Legs/Feet
____

Habits:
☐ Smoking
Packs/Day___
☐ Alcohol
Drinks/Day _____
☐ Coffee
Cups/Day ______
☐ Soda Pop
Cups/Day _____

Exercise:
☐ None
☐ Moderate
☐ Daily
Type
____

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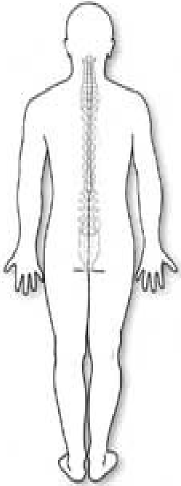
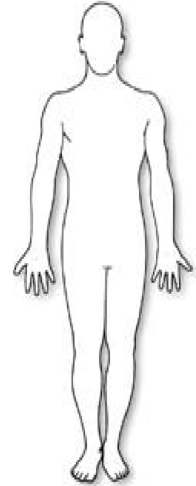


Severity of Pain
List region of pain and circle severity number
(1=least, 10=Greatest) MARK PAIN REGION

Burning –Stabbing-Sharp-Constant

ex. Neck__________Sharp______
1 2 3 4 5 6 7 (8) 9 10

MARK PAIN AREA
+++ Burning
000 Stabbing
--- Sharp
| | | Constant
XXX Other



Regions

1) Neck ________________
1 2 3 4 5 6 7 8 9 10
2) Mid Back ________________
1 2 3 4 5 6 7 8 9 10
3) Low Back ________________
1 2 3 4 5 6 7 8 9 10
4) Hips ________________
1 2 3 4 5 6 7 8 9 10
5)Arms/Hand ________________
1 2 3 4 5 6 7 8 9 10
6)Legs/Feet ________________
1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using the code listed above.

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ☐ 303.9 Alcoholism
- ☐ 280 Anemia
- ☐ 541. Appendicitis
- ☐ 716. Arthritis
- ☐ 239. Cancer
- ☐ 052. Chicken Pox
- ☐ 250. Diabetes
- ☐ 690 Eczema
- ☐ 345 Epilepsy
- ☐ 240. Goiter
- ☐ 429.9 Heart Disease
- ☐ 042. HIV Positive
- ☐ 487. Influenza
- ☐ 724.2 Low back pain
- ☐ 055. Measles
- ☐ 319. Mental Disorder
- ☐ 072 Mumps
- ☐ 511. Pleurisy
- ☐ 480. Pneumonia
- ☐ 045. Polio
- ☐ 390. Rheumatic fever
- ☐ 737.30 Scoliosis
- ☐ 846. Sprain /Strain Sacroiliac
- ☐ 847.0 Whiplash

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother – Living Y ☐ N ☐	☐	☐	☐	☐	☐
Father – Living Y ☐ N ☐	☐	☐	☐	☐	☐
Brother(s), # _____	☐	☐	☐	☐	☐
Sister(s), # ______	☐	☐	☐	☐	☐
Adoption History	☐	☐	☐	☐	☐

Please enter: "2" previously, "3" (presently) of all the following signs and symptoms not applicable, put ~~NA~~. A complete history and Understanding of your health will facilitate care. Behind condition, put number of times per month it occurs.

GENERAL SYMPTOMS
____ 784.0 Headache
____780.6 Fever
____ 780.99 Chills
____ 780.8 Night Sweats
____780.2 Fainting
____780.4 Dizziness
____780.3 Convulsions
____780.52 Loss of Sleep
____780.7 Fatigue
____799.2 Numbness or pain in arms/legs/hands
____995.3 Alleger (to what?)
____786.07 Wheezing
____792.2 Neuralgia

GASTRO-INTENSTINAL
___783 Poor Appetite
___536.8 Poor Digestion
___994.2 Starvation
___787.3 Belching or Gas
___787.0 Vomiting
___578.0 Vomiting Blood
___536.8 Pain over stomach
___564 Constipation
___787.91 Diarrhea
___562.1 Colon Trouble
___455.6 Hemorrhoids (Piles)
___776.7 Fluid Retention
___873.9 Liver Trouble
___274 Gout
___782.4 Jaundice
___575.9 Gall Bladder Trouble

EAR/EYE/NOSE/THROAT
___368.9 Poor Vision
___378.0 Crossed Eyes
___379.91 Pain in Eyes
___389.9 Deafness
___388.70 Earache
___388.30 Ear Noises
___388.60 Ear Discharges
___478.1 Nasal Obstruction
___784.7 Nose Bleeds
___462. Sore Throat
___784.49 Hoarseness
___477.9 Hay Fever
___493.9 Asthma
___460 Frequent Colds
___240.9 Enlarged Thyroid
___463 Tonsillitis
___473. Sinus Trouble

RESPITORY
___ 786.2 Chronic-Cough
___786.3 Spitting Blood
___786.4 Spitting Phlegm
___786.50 Chest Pain
___786.09 Difficulty Breathing

GENITO-URINARY
___788.4 Frequent Urination
___788.1 Painful Urination
___599.7 Blood In Urine
___590 Kidney Infection
___788.3 Bedwetting
___788.3 Inability to control urine
___601.9 Prostate Trouble

FOR WOMEN ONLY
___625.3 Painful Periods
___626.2 Excessive Flow
___626.4 Irregular Cycle
___627.2 Hot Flashes
___625.3 Cramps or Backaches
___623.5 Vaginal Discharge
___ Pregnant at this time
Last Pap ___________
By Whom _____________
Other _________________

MUSCLES AND JOINTS
___728.9 Weakness
___781.0 Twitching
___723.5 Stiff Neck
___724.5 Backache
___719.0 Swollen Joints
___781 Tremors
___729.5 Foot Trouble
___724.5 Pain Between Shoulders
___737.3 Spinal Curvature

CARDIO –VASCULAR
___785.0 Rapid Heart
___427.89 Slow Heart
___401.9 High Blood Pressure
___458.9 Low Blood Pressure
___786.51 Pain Over Heart
___429.9 Heart Trouble
___786.51 Pain Over Heart
___429.0 Heart Trouble
___719.07 Swelling Ankles
___459.9 Poor Circulation
___454.9 Varicose Veins
___436 Strokes
___785.1 Palpitations

SKIN OR ALLERGIES
___680. Skin Eruptions-#
___698.9 Itching
___924.9 Bruising Easily
___701.1 Dryness
___680.9 Boils
___782. Sensitive Skin
___708.9 Hives or Allergy
___692.9 Eczema
Medicines ____________
____
____
____

IN PATIENT/ OUT PATIENT OPERATIONS AND PROCEDURES –HOSPITILIZATION

DATE	DATE	DATE	DATE
_______________Vaccinations	________________Other	_________________Rectal Surgery	_________________Thyroid
_______________Tonsillectomy	________________Tubes in ears	_________________other	_________________Stomach
_______________Gall Bladder	________________Appendectomy	_________________Sinus	_________________Other
_______________Back Operation	________________Female Organs	________________Hernia	

Hospital Stays ____
Other Surgeries ____
Have you ever had any accidents or falls of any kind? List dates: ☐ Care_________________________ ☐ RV ________________
☐ Sports __________________ ☐ School _____________ ☐Other __________
List any broken bones (factures) or dislocations: ____
Have you ever been on crutches? ☐ Yes ☐ No Why? ____
Have you ever had a lapse of memory? ☐ Yes ☐ No Have you ever been unconscious? When ___________________________
Have you ever had X-rays Taken? ☐ Yes ☐No When? __________________________ By Whom?______________________________
For what ailments were these x-rays made? ____
Do you suffer from any condition other than that for which you are now consulting us now? _____________________________
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 Doctors 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 Doctor's 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate though the use of Chiropractic Health Care. I give authority for these procedures to be performed. It is understood and agreed the amount paid the doctor for the x-rays is for examination only and the x-ray negatives will remain the property of the office, being on file where they may be seen at any time while I am an active patient in this offices. . The patient also agrees hat 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 no for any medical diagnosis. Patient may obtain copies of their file and x=rays upon request. Copying fees may apply.

Patient Signature ____ Date ___________________________
Guardian Signature ____ Date ___________________________
Doctor Signature ____ Date ___________________________