CASE HISTORY

DATE________________

NAME____

ADDRESS ____________________ CITY ____________ STATE _____ ZIP _____

DATE OF BIRTH ____________________ SOCIAL SECURITY NO. ________________

HOME PHONE______________ WORK PHONE______________ MARITAL STATUS____________

SPOUSE'S NAME ____

CHILDREN'S NAMES AND AGES __________________________________

____

NAME OF EMPLOYER ____________________________ OCCUPATION __________

HOW LONG EMPLOYED ________________ WHO REFERRED YOU ________________

____

PLEASE DESCRIBE YOUR MAJOR COMPLAINTS AND SYMPTOMS ________________

____

____

WERE THEY CAUSED BY A STRAIN? ____ STRESS? ____ FALL? ____ OVERUSE? ____

EXERCISE? ____ WORK RELATED? ____ AUTO ACCIDENT? ____ UNKNOWN? ____

WHEN DID THIS OCCUR? ________________ REOCCURRING CONDITION? ________________

ANY FAMILY HISTORY OF THIS CONDITION? ____________________________

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? ____________

M.D. ____ D.O. ____ D.C. ____ NAME OF DOCTOR ________________________

DIAGNOSIS ____________________ TREATMENT ____________________

WERE X-RAYS TAKEN? _____ WHEN? _____ LENGTH OF TIME UNDER HIS/HER CARE? ________

RESULTS ____

____

WHAT ACCIDENTS/FRACTURES HAVE YOU HAD? (INCLUDE DATES) ________________

____

WHAT MAJOR SURGERY HAVE YOU HAD? (INCLUDE DATES) ____________________

____

LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING ____________________

WITHIN THE LAST 6 MONTHS? ____________________________________

____

____

CEEE PHONE____________________ e-mail________________________

Emergency Contact not living with you:

Name: ______________________________

Address: ______________________________

Home Phone: ______________ Cell Phone: ______________

Patient Cell Phone: ______________________________

Patient E-mail: ______________________________

Patient Name:____________________ Date:__________

CHIEF COMPLAINT – HPI FORM

CHIEF COMPLAINT: ☐ Pain ☐Numbness ☐ Stiffness ☐Weakness ______________________

Body Area Involved: ☐ Head/Neck ☐ Spine/Ribs/Pelvis ☐ Upper Extremity ☐ Lower Extremity

Condition Type: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

1.) *Does anyone else in the family have this same or similar problem? (Check family history.)*______________________

____

MECHANISM OF ONSET:

2.) *Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly relatec to this problem? (Example: fall, auto injury, sports trauma, repetitive motion on the job.)* ______________________

____

☐ Auto ☐ Restrained ☐ Unrestrained ☐ Driver ☐ Passenger ☐ Pedestrian ☐ See Accident Hx Form
☐ Work ☐ Overexertion ☐ Lifting ☐ Repetitive Motion ☐ Fall ☐ See Accident Hx Form
☐ Other ☐ Etiology Unk ☐ Slip/Fall ☐ Overexertion ☐ Recreation ☐ Slept Wrong ☐ Other__________
☐ No Injury

LOCATION: ______________________ Right/Left/Bilatera

SYMPTOMS: *When this problem is at it's worst, can you explain in your words how exactly it feels? Does it radiate?* __________

____

QUALITY:

☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Sharp__________
☐ Shooting ☐ Stabbing ☐ Tingling ☐ Radiating ☐ Other

SEVERITY:

☐ Minimal ☐ Mild ☐ Mild/Moderate ☐ Moderate ☐ Moderate/Severe ☐ Severe

On a scale of 0-10, where 10 is the worst pain you have ever felt, can you rate that pain?

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

*How does that make you feel?*______________________

DURATION: How long have you been suffering from this problem? (Major Complaint) __________

Sx Started: ___/___/___ Sx Worsened: ___/___/___ Sx Last Occurred: ___/___/___
Injury Date: ___/___/___ Sx Last Episode: ___/___/___ Accident Occurred: ___/___/___

TIMING:

☐ Worse AM , ☐ Worse PM ☐ Worse w/ Activity ☐ Intermittent ☐ Constant ☐ Worse at Night

*How often do you find yourself suffering from this problem?*______________________

How long does the problem last? (Get all the details of timing) ______________________

CONTEXT:

Better When: ☐ Hot ☐ Cold **Worse When:** ☐ Hot ☐ Cold ☐ Damp

ASSOCIATED SIGNS SYMPTOMS:

☐ Headache ☐ Swelling ☐ Spasm ☐ Numbness ☐ Dizziness ☐ Nausea ☐ Fatigue
☐ Stiffness ☐ Irritability ☐ Other __________
☐ Weakness - Location __________ ☐ Radiation - Location __________

Patient Name ______________________ Date ____________

HEADACHE

Location:	☐ Occipital	☐ Frontal	☐ Temporal	☐ Pareital	☐ Sinus	
Quality:	☐ Dull	☐ Sharp	☐ Throbbing	☐ Stabbing	☐ Aura	☐ No Aura
Types:	☐ Hat Band	☐ Cluster	☐ Migraine	☐ Tension		

MODIFYING FACTORS:

Since the time you began suffering from this problem, what if anything have you tried so far that permanently helped you? (Ex: Ice, Heat, Rest, OTC Meds, Prescriptions, Physical Therapy) ______________________

How much? ______________________ *How often?* ______________________

Symptoms Better With: ☐ Activity ☐ Bending ☐ Cold ☐ Heat ☐ Massage ☐ Movement
☐ OTC Meds ☐ Rx Meds ☐ Rest ☐ Stretching ☐ Sitting ☐ Standing
☐ Twisting ☐ Walking

Symptoms Worse With: **As Noted in Social History**

Has anything that you have done, thus far, fixed your problem? YES or NO

When this problem is at it's worst, does it make you feel older than you are? In other words, does this condition the way you have described it so far seem to you to be normal for your actual age? YES or NO How old? ______________________

Have you become discouraged/frustrated about this problem? (from above) ______________________

(IF NO) So what would you say it was if not discouraged? ______________________

SOCIAL HISTORY QUESTIONNAIRE

Give me an example of a day when your problem was at it's worst, how did it ruin things for you? ______________________

____

How does this problem affect your family? ______________________

____

DAILY ACTIVITIES: **Effects of Current Condition on Performance**

Activity				
Care - Family Member				
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Change Positions -				
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Self Care - Bathing	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Self Care - Dressing	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Self Care - Shaving	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Yardwork	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Panfull (limits)	☐ Unable to Perform

Patient Name ______________________ Date __________

EMPLOYMENT:

Occupation: ______________________ **Work Hours Per Day:** ______________________

Job Classification: ☐ Sed (<5 lbs) ☐ Light (5-20 lbs) ☐ Moderate (20-50 lbs) ☐ Heavy (>50 lbs)

Lifting Frequency: ☐ Constant (66-100% of day) ☐ Frequent (33-66% of day) ☐ Occasional (0-33% of day)

Lifting Postures: ☐ Torso ☐ Knee ☐ Arm ☐ Shoulder ☐ High Near ☐ Off Posture

Work Activity Postures:

Sitting:	____ Hours per day	Standing:	____ Hours per day	Walking:	____ Hours per day
Bending	____ Hours per day	Climbing:	____ Hours per day	Pushing:	____ Hours per day
Pulling:	____ Hours per day	Kneeling:	____ Hours per day	Reaching:	____ Hours per day
Twisting:	____ Hours per day				

Repetitive Activities:

Computer:	____ Hours per day	Phone:	____ Hours per day	Machinery:	____ Hours per day
Hand Tools:	____ Hours per day	Assembly:	____ Hours per day	Grasping:	____ Hours per day

Condition's Effect on Job Performance: ☐ No Effect ☐ Painful (can do) ☐ Painful(limits) ☐ Unable to Perform

RECREATIONAL ACTIVITY:

______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

What activities does this problem prevent you from doing, either partially or totally, that you would really like to be doing again? ______________

How does this problem prevent you from doing that? ______________

This problem you described has been going on for years/months. How do you see it in the future if you don't make the commitment to improve the condition? (above B-W-S) ______________

So, taking into consideration what we have discussed here so far, do you see that you would need to change something you are doing in order for your (condition above) to improve? YES or NO ______________

On a scale of 1 to 10, ten being the highest, rate your commitment to getting rid of the problem? ______________

Concerns that could interfere with your commitment? (Time, Transportation, Other) Specify: ______________

Doctor Signature: ______________________ Date: ______________

Other doctors seen for this condition? ☐ Yes ☐ No Who? ____________________

Type of treatment: ____________________ Results: ____________________

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin ☐ Allergy Medicine

☐ Anti-Depressants ☐ Other: ____________________

Do you wear heal lifts? ☐ Yes ☐ No Side Lift ☐ Yes ☐ No Inter Soles ☐ Yes ☐ No Arch Supports ☐ Yes ☐ No Orthatics ☐ Yes ☐ No

Any other conditions you feel we should know about - even if unrelated? ____________________

____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can effect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections even if "NONE".

Constitutional: ☐ None	☐ Chills ☐ Weight Loss	☐ Daytime Somnolence	☐ Fatigue	☐ Fever	☐ Night Sweats	☐ Weight Gain
Eyes/Vision: ☐ None	☐ Blindness ☐ Field Cuts	☐ Blurred Vision ☐ Glasses/Contacts	☐ Cataracts ☐ Glaucoma	☐ Change in Vision ☐ Itching	☐ Double Vision ☐ Photophobia	☐ Eye Pain ☐ Tearing
ENT: ☐ None	☐ Bleeding ☐ Ear Pain ☐ Hoarseness ☐ Sinus Infections	☐ Dentures ☐ Fainting ☐ Loss of Smell ☐ Snoring	☐ Difficulty Swallowing ☐ F equent Sore Throats ☐ Nasal Congestion ☐ Tinnitus (Ringing in Ears)	☐ Discharge ☐ Headaches ☐ Nose Bleeds ☐ TMJ	☐ Dizziness ☐ Hearing Loss ☐ PND (Post Nasal Drip)	☐ Ear Drainage ☐ History of Head Injury ☐ Rhinorrhea (Runny Nose)
Respiration: ☐ None	☐ Asthma	☐ Cough	☐ Coughing up Blood	☐ Shortness of Breath (SOB)	☐ Sputum Production	☐ Wheezing
Cardio: ☐ None	☐ Angina ☐ Palpitations	☐ Chest Pain ☐ PND	☐ Claudication ☐ SOB with Exertion	☐ Heart Murmur ☐ Swelling of Legs	☐ Heart Problems ☐ Ulcers	☐ Orthopnea ☐ Varicose Veins
Gastro: ☐ None	☐ Abdominal Pain ☐ Heartburn ☐ Regurgitation	☐ Belching ☐ Hemorrhoids ☐ Stool Caliber	☐ Black Tarry Stools ☐ Indigestion ☐ Stool Color	☐ Constipation ☐ Jaundice ☐ Stool Consistency	☐ Diarrhea ☐ Nausea ☐ Vomiting	☐ Difficulty Swallowing ☐ Rectal Bleeding ☐ Vomiting Blood
Female: ☐ None	☐ Breast Lumps/Pain ☐ Vaginal Bleeding	☐ Burning Urination ☐ Vaginal Discharge	☐ Cramps	☐ Frequent Urination	☐ Irregular Menstruation	☐ Urine Retention
Male: ☐ None	☐ Burning Urination	☐ Erectile Dysfunction	☐ Frequent Urination	☐ Hesitancy/Dribbling	☐ Prostate	☐ Urine Retention
Endocrine: ☐ None	☐ Cold Intolerance ☐ Goiter	☐ Diabetes ☐ Hair Loss	☐ Excessive Appetite ☐ Heat Intolerance	☐ Excessive Hunger ☐ Unusual Hair Growth	☐ Excessive Thirst ☐ Voice Changes	☐ Frequent Urination
Skin: ☐ None	☐ Changes in Nail Texture ☐ Itching	☐ Changes in Skin Color ☐ Paresthesias	☐ Hair Growth ☐ Pruritis	☐ Hair Loss ☐ Rash	☐ History of Skin Disorders ☐ Skin Lesions/Ulcers	☐ Hives ☐ Varicosities
Nervous: ☐ None	☐ Dizziness ☐ Numbness ☐ Tremor	☐ Facial Weakness ☐ Seizures ☐ Unsteadiness of Gait	☐ Headache ☐ Sleep Disturbance	☐ Limb Weakness ☐ Slurred Speech	☐ Loss of Consciousness ☐ Stress	☐ Loss of Memory ☐ Strokes
Psychologic: ☐ None	☐ Anhedonia ☐ Depression	☐ Anxiety ☐ Insomnia	☐ Appetite ☐ Memory Loss	☐ Behavioral Change ☐ Mood Change	☐ Bipolar	☐ Confusion
Allergy: ☐ None	☐ Anaphalaxis	☐ Food Intolerance	☐ Itching	☐ Nasal Congestion	☐ Sneezing	
Hematology: ☐ None	☐ Anemia ☐ Lymph Node Swelling	☐ Bleeding	☐ Blood Clotting	☐ Blood Transfusions	☐ Bruising	☐ Fatigue

PAST HEALTH HISTORY – **Please fill out carefully as these problems can affect your overall course of care.**

Childhood Illness: ☐ None
- ☐ ADD ☐ Allergies/Hayfever ☐ Asthma ☐ Atopic Dermatitis ☐ Cerebral Palsy ☐ Chicken Pox
- ☐ Depression ☐ Diabetes ☐ Fetal Drug Exposure ☐ Food Allergies ☐ Headaches ☐ Hepatitis
- ☐ Measles ☐ Mumps ☐ Rash ☐ Seizure Disorder ☐ Sickle Cell Anemia ☐ Spina Bifida
- ☐ Unusual Childhood Illnesses

Adult Illnesses: ☐ None
- ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chicken Pox ☐ CRPS (RSD)
- ☐ CVA (Stroke) ☐ Depression ☐ Diabetes (Insulin Dep) ☐ Diabetes (NIDDM - Noninsulin) ☐ Eye Problems ☐ Heart Disease
- ☐ Hepatitis ☐ Hypertension ☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease ☐ Psychiatric Problems
- ☐ Seizures ☐ Similar Symptoms ☐ STD's ☐ Suicide Attempts ☐ Thyroid Problems

Surgeries: ☐ None
- ☐ Angioplasty ☐ Appendectomy ☐ Caesarean Section ☐ Cardiac Catheterization ☐ Carpal Tunnel Repair ☐ Coronary Bypass
- ☐ Cosmetic ☐ D&C ☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hysterectomy ☐ Joint Reconstruction
- ☐ Joint Replacement ☐ Laminectomy ☐ Mastectomy ☐ Pacemaker Insertion ☐ Spinal Fusion ☐ Tonsillectomy
- ☐ Gallbladder
- ☐ Other ______________________________

Ob/Gyn: Describe: ______________________________
☐ None

Injuries: Describe: ______________________________
☐ None

Immunizations: ☐ None
- ☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ MMR ☐ [illegible]
- ☐ PPD ☐ Small Pox ☐ TD ☐ Varivax

Non-Drug Allergies: Describe: ______________________________
☐ None

FAMILY HISTORY

	Alive	Deceased	Condition
General Family	☐	☐	________
Father	☐	☐	________
Mother	☐	☐	________
Paternal Grandfather	☐	☐	________
Paternal Grandmother	☐	☐	________
Maternal Grandfather	☐	☐	________
Maternal Grandmother	☐	☐	________
Son(s)	☐	☐	________
Daughter(s)	☐	☐	________
Brother(s)	☐	☐	________
Sister(s)	☐	☐	________

SOCIAL HISTORY

Alcohol: ☐ None ☐ Beer ☐ Liquor ☐ Social Consumption ☐ Wine Amount ________

Diet:
- ☐ High Fat Diet ☐ High Fiber ☐ High Protein ☐ High Salt Intake
- ☐ Low Calorie Intake ☐ Low Carbohydrate ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

Education: Level or Degree Attained: ______________________________

Substance: ☐ Denies Any ☐ Denies IV Drugs Not Used Since ________ Used Drugs For ________

Tobacco: Type ________ Amount ________

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DR. CAROLYN BALLARD

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FINANCIAL POLICY

We are committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. Payment is expected at time of service.

2. We will file your insurance for you if we are a participating provider of your plan. You will be responsible for any and all services in excess of your insurance limits as well as all non-covered services.

3. All co-payments are due at the time of service.

4. If we are not participating providers of your plan, full payment is due at the time of service, unless prior arrangements have been made. We will give you complete forms that will be accepted by your insurance company for reimbursement.

We will mail to you a monthly billing statement for any outstanding balances.

I acknowledge that I understand and accept this financial policy.

____________________________ Signature

____________________ Date

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We accept most insurance after verification of coverage. We will also file your insurance from our office. You, the patient, are responsible for your bill if your insurance does not cover the charges incurred. You are also responsible for any collection costs if necessary.

Our office is dedicated to your health; therefore it is our policy to make chiropractic care available for everyone. If the cost of your care presents a problem, please discuss your situation with the office manager.

Thank you

____________________________ Date________________________
Patient or responsible party

____________________________ Date________________________
Witness signature

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