

Frideres Chiropractic Clinic P.C.
Patient's Case History

Personal:

Date ____/____/____ Case # _____
Patient's Name _____ SSN _____
Address _____ City _____ State _____ Zip _____
Date of Birth ____/____/____ Gender _____ Age _____ Marital Status _____
Home Phone (____)____-____ Work Phone(____)____-____ E-Mail _____
Employer _____ Employment Status _____
Employer's Address _____ City _____ State _____ Zip _____
Who Referred You To Our Office? _____
What Are Your Expectations And How May We Exceed Them? _____

Insured's Name _____ Insured's SSN _____
Insured's Address _____ City _____ State _____ Zip _____
Insured's Date of Birth _____ Insured's Phone (____)____-____
Insurance Company(s) _____ Policy Number _____
Insurance Address _____ City _____ State _____ Zip _____
Medical Doctor(s) _____ City(s) _____
Previous Chiropractic Care? Y / N Date of Last Adjustment _____
Doctor of Chiropractic's Name _____ City _____

Present Complaint:

Rank the various symptoms on a scale from 1-10: (good) 1 2 3 4 5 6 7 8 9 10 (bad)
Where exactly is the problem? _____
When did the problem occur? _____
Is the problem a result of : Injury at work? Y / N Car Accident? Y / N
How did the problem occur? _____
What makes it better? _____
What makes it worse? _____
Have you ever experienced this problem before? When? What Was Done? _____
Have you tried any medications/home remedies? _____
Have you seen any other health care professionals? _____

Past History:

Accidents? _____
Allergies? _____
Surgeries? _____
Medications? _____
Hospitalizations? _____

Social History:

Smoker: Y / N Packs per day _____ Commute _____ minutes to work
Drink _____ cups of coffee per day Work _____ hours per week (avg)
Drink _____ alcoholic drinks per day Exercise _____ hours per week

PAST HISTORY: Please check all that you have or have had:

GENERAL SYMPTOMS:

- Headaches
- Fatigue
- Chills
- Fever
- Sinus pressure
- Weight loss
- Allergies
- Dizziness
- Fainting

SKIN:

- Eczema
- Skin eruptions
- Boils
- Hives
- Pimples
- Rashes
- Dryness

GENITO-URINARY:

- Frequent urination
- Painful urination
- Blood in urine
- Bed wetting
- Prostate
- Kidney stone or infection

GASTRO-INTESTINAL:

- Gas / Burning sensation
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Poor appetite
- Pain in abdomen
- Jaundice

RESPIRATORY:

- Spitting blood/phlegm
- Chronic cough
- Difficult breathing
- Asthma

FAMILY HISTORY: Please check all that are appropriate and the individual's relation to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia (Relation) _____ | <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Multiple sclerosis _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Prostate problems _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Problems _____ | <input type="checkbox"/> Psoriasis _____ |
| <input type="checkbox"/> Chronic neck pain _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Rheumatoid arthritis _____ |
| <input type="checkbox"/> Chronic back pain _____ | <input type="checkbox"/> Hypoglycemia _____ | <input type="checkbox"/> Scoliosis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Thyroid disease _____ |

FEMALE HISTORY:

- Breast
- Menopause
- Excessive flow
- Irregular cycle
- Vaginal discharge
- Painful menstruation

CARDIO-VASCULAR:

- High blood pressure
- Low blood pressure
- Heart attack
- Poor circulation
- Strokes
- Rapid heart
- Chest pain

NERVOUS SYSTEM:

- Eyes
- Ears
- Sense of touch
- Muscular movement
- Tremors
- Incoordination
- Equilibrium
- Smell
- Taste

PAST ILLNESSES:

- Appendicitis
- Diphtheria
- Measles
- Mumps
- Chickenpox
- Whooping cough
- Rheumatic fever
- Pneumonia
- Anemia
- Heat exhaustion

MUSCULO-SKELETAL:

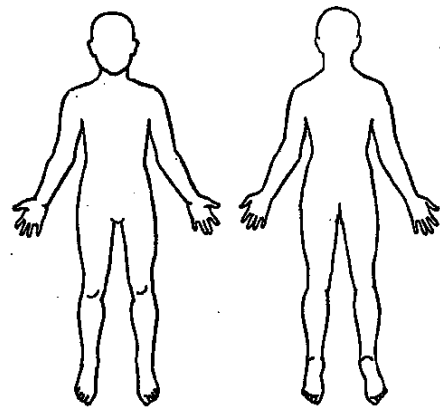
- Weakness (describe) _____
- Fracture _____
- Sprain/Strain _____
- Dislocation _____
- Congenital defect _____

CURRENT CONDITIONS:

- | | |
|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other _____ |

PAIN DIAGRAM:

Front Back



To the best of my knowledge, all statements made above are true: _____

(signature)