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 (____)_____-________ Cell Phone(____)_____-________ Cell Carrier: _________________

E-mail:____

Would you like to sign up for appointment reminders? (Circle one) Text Email None

Employer ____ Employment Status? Full or Part

Emp. Address ________________________ City ________ State ___ Zip ______Work Phone____________

Emergency Contact:___________________________ Phone:_________________ Relation________________

Who Referred You To Our Office?____

What Are Your Expectations And How May We Exceed Them?______________________________________

____

Policy Holder's Information: (Write Self if patient is the policy holder.)

Name/Relation____ DOB ________ Phone (____)_____-________

Address ____ City ______________ State _______ Zip ________

Insurance Company(s) __________________________ Policy #____________________Group #___________

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 _____________

Drink _________ cups of coffee per day

Drink _________ alcoholic drinks per day

Commute _________ minutes to work

Work ___________ hours per week (avg)

Exercise _________ hours per week

PAST HISTORY: Please circle 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
Athsma

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

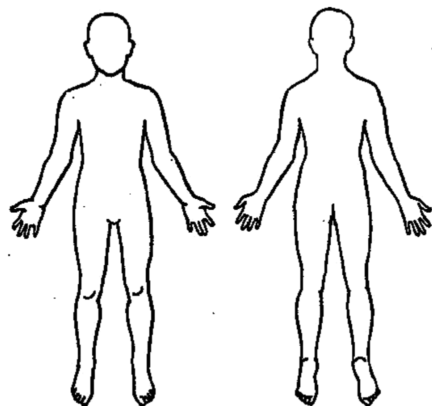
PAST ILLNESSES:
Appendicitis
Diphtheria
Measles
Mumps
Chickenpox
Whooping cough
Rheumatic fever
Pneumonia
Anemia
Heat exhaustion

MUSCULO-SKELETAL:
Weakness (describe)___________________
____
Fracture _____________________________
____
Sprain/Strain ________________________
____
Dislocation ___________________________
____
Congenital defect____________________
____

CURRENT CONDITIONS:

AIDS	Kidney disease
Anemia	Low Back Pain
Multiple Sclerosis	Lupus
Cancer	Migraines
Muscular Dystrophy	Diabetes
Eczema	Polio
Emphysema	Pregnancy
Epilepsy	Prostate
Goiter	Tuberculosis
Heart problems	Scoliosis
Stroke	Thyroid disease
Low blood sugar	Arthritis
High blood pressure	Other___________

PAIN DIAGRAM:
Front Back



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

Anemia (Relation)_____________
Arthritis ______________________
Cancer _______________________
Chronic neck pain _____________
Chronic back pain _____________
Diabetes ______________________
Emphysema __________________
Epilepsy _____________________
Heart Problems ________________
High Blood Pressure____________
Hypoglycemia ________________
Migraines _____________________
Multiple sclerosis ______________
Prostate problems _____________
Psoriasis ______________________
Rheumatoid arthritis ____________
Scoliosis ______________________
Thyroid disease ________________

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

(signature)