



CASE HISTORY

PLEASE PRINT

Name: _____ Home Phone: _____

Address: _____ City: _____ Zip: _____

Age: _____ Birthdate: _____ Marital Status: M S W D Number of Children: _____

Names of Children: _____

Occupation: _____ Employer: _____ Office Phone: _____

Email Address: _____ Your SS#: _____

Name of Spouse or Guardian: _____ Occupation: _____

Their SS#: _____ Employer: _____ Phone: _____

Name of Nearest Relative NOT Living With You: _____ Phone: _____

Referred By: _____ Date of Last Physical Exam: _____

If you have ever suffered from the following symptoms or do so currently, please check the appropriate box ("P" = in the past, "C" = currently):

Fractured bones	<u>P</u>	<u>C</u>	Neck Pain or Stiffness	<u>P</u>	<u>C</u>	Numbness, Tingling, Pain in	<u>P</u>	<u>C</u>
Auto Accidents			R L	<input type="checkbox"/>	<input type="checkbox"/>	Buttocks, Legs, Feet, Toes		
___ 0-1 years ago			Numbness, Tingling, Pain in	R	L	R L	<input type="checkbox"/>	<input type="checkbox"/>
___ 1-5 years ago			Arms, Hands, Fingers			Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>
___ 5 years or more			R L	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain, Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Other accidents, falls	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain or Click (TMJ)			Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	R L	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Excessive Standing,			High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions, Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sitting, Riding, Bending, Lifting,			Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	Twisting	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	R	L	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds, Flu	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness			Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Depressed	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	R	L	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Blurred or Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergy, Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain, Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Under Stress	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain, Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems, PMS	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Pain with Cough, Sneeze	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	R	L	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	AIDS, HIV	<input type="checkbox"/>	<input type="checkbox"/>
Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>						

Prior to answering the following questions, please read the pamphlet entitled "Subluxation." Page 3

Patient: _____ Date: _____

PATIENT HISTORY

1. What is your main complaint? _____

2. Vertebral Subluxations can cause irritation to different fibers within nerves. On the scale below, please circle the severity of your main complaint (at its worst)?

None	Slight	Mild	Moderate	Severe					
1	2	3	4	5	6	7	8	9	10

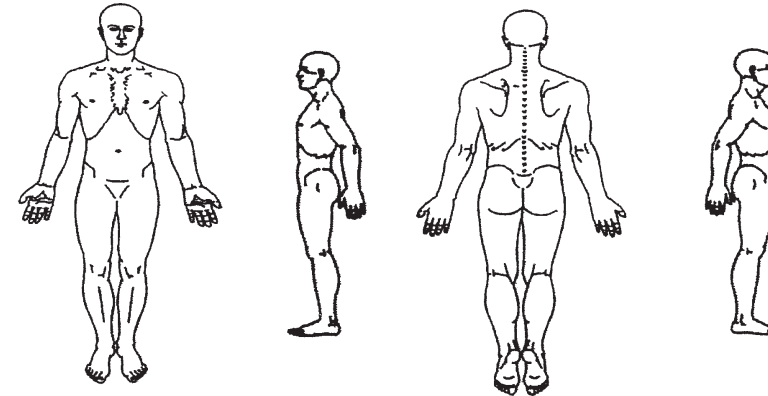
3. Subluxations can put pressure on the spinal cord which can be constant or occasional. On the scale below, please circle the percentage of time you experience your main complaint:

Occasional	Intermittent	Frequent	Constant								
0	10	20	30	40	50	60	70	80	90	100	%

4. How long have you been experiencing your main complaint? _____ Date of onset: _____

5. On the diagram below, please show where you are experiencing all of your present complaints using the following letters:

A: Ache B: Burning Pain C: Cramping D: Dull Pain
R: Throbbing Pain N: Numbness T: Tingling S: Sharp



6. Pressure on the spinal cord or nerves can be worse in the AM or PM.

When do you notice it most? AM PM

How long does it last? ___ Mins ___ Hrs.

7. What makes it feel better? _____

8. What makes it feel worse? _____

9. Have you ever had this problem in the past? Yes No

10. I have been hospitalized been treated by another chiropractor

been treated by another specialty provider

never received care for this problem

(Drs. names: _____)

11. Have you lost time from work because of it? Yes No

Dates: _____ to _____

12. Are you pregnant? Yes No

13. What was the first day of your last menstrual cycle? _____

14. Number of pregnancies? _____ Miscarriages? _____

Do you have pain and/or difficulty performing any of the following activities: (Check)

Personal Care _____

Lifting _____

Reading _____

Concentrating _____

Work _____

Driving _____

Sleeping _____

Recreation _____

Walking _____

Sitting _____

Standing _____

Social Life _____

Signature: _____

Date: ___/___/___

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS



Dr. John J. Hanna, Director

Matthews Family Chiropractic

Dr. Mechelle F. Hanna

Windsor Square

9808 Northeast Parkway

Matthews, NC 28105

(704) 845-0699

Date of Accident: _____ Hour _____ AM ___ PM ___ Location _____

How did accident occur? Auto Collision On-the-Job Injury Other _____

If not an auto collision, please describe the circumstances: _____

Did you report the injury to your foreman or employer? Yes No

Did he (they) recommend care at our office? Yes No

If an auto accident, were you: Driver Passenger Pedestrian

If auto collision, were you struck from: Behind Right Side Left Side Front Auto was parked

Did your car strike the other(s) involved? Yes No

OR did the other car strike yours? Yes No Undetermined

As a result of the accident, were traffic citations issued to you? Yes No

To the driver of the other car? Yes No

To the driver of your car? Yes No

List the extent of the injuries as you know them: _____

Did you require post-accident hospitalization? Yes No

Check symptoms you have noticed since the accident:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | |

Symptoms other than above: _____

Have you lost any days of work? Yes No Dates _____

Insurance Companies Involved:

My Company: _____

Company of person responsible for injuries: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Previous Chiropractic Care? Yes No Chiropractor's Name: _____

What was the reason for your initial visit? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

Did you follow it? _____ If not, why? _____

Why are you changing chiropractors? _____

Have you been treated for any health condition by a physician in the last year? _____

Describe: _____

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription): _____

What are your health goals? _____

How do you expect to achieve these goals? _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: _____

Method of payment you plan to use to take care of today's charges: Cash Check Visa/Mastercard

Are you insured? () Yes () No Company Name: _____

***Please show all I.D. Cards to the receptionist.**

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Patient's Signature: _____ Date: _____

I understand and agree that health and accident insurance policies are an arrangement between an **insurance carrier and myself**. Furthermore, I understand that Matthews Family Chiropractic will prepare any necessary reports and forms as a courtesy to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Matthews Family Chiropractic will be credited to my account on receipt. **However, I clearly understand and agree that all services rendered me are charged directly to me regardless of insurance, 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 agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Matthews Family Chiropractic to obtain a credit report if deemed necessary.

Patient or Guardian Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Driver's License #: _____ Expiration Date: _____

Mastercard or Visa #: _____ Expiration Date: _____