CASE HISTORY

Name_____ Birth date_____ age_____

Address_____ City_____ State_____

Zip_____ Telephone home: _____ Cell: _____

Sex: **M F** Status **M S W D** Spouse's name_____ #of children____

Your Occupation_____ Employer_____

Person Responsible for account_____ **Referred by**_____

What is your major compliant today?_____
_____
How long have you had this condition?_____
Have you had this or a similar condition in the past?_____
What aggravates your condition?_____

Is condition: Constant ☐ Comes and goes ☐

Is this condition getting progressively worse? Yes ☐ No ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other ☐
Other Doctors seen for this condition? Name_____
MD DC DO DDS
X-Rays_____ Date_____ Other Tests for this condition:_____
Length of time under care_____
Treatment_____
Medications for this treatment_____
Results: _____

Were you off work? Yes ☐ No ☐ If yes for how long?_____

Is the condition a result of a work injury? Yes ☐ No ☐

Is this condition a result of an accident? Yes ☐ No ☐

Other complaints_____

List surgical operations_____

Please list all Medications you are currently Taking

_____
_____
_____

Signature_____ Date_____

IMPORTANT: Please check (X) all present symptoms.

HEAD:

Headache
- ☐ sinus (allergy)
- ☐ entire head
- ☐ back of head
- ☐ forehead
- ☐ temples
- ☐ migraine

☐ Head feels heavy
☐ Loss of memory
☐ Light-Headedness
☐ Fainting
☐ Light bother eyes
☐ Blurred vision
☐ Double vision
☐ Loss of vision
☐ loss of taste
☐ Loss of balance
☐ Dizziness
☐ Loss of hearing
☐ Pain in ears
☐ Ringing in ears
☐ Buzzing in ears

NECK:

☐ Pain in neck
☐ Neck pain with movement
- ☐ forward
- ☐ backward
- ☐ turn to lett
- ☐ turn to right
- ☐ bend to left
- ☐ bend to right

☐ Pinched nerve in neck
☐ Neck feels out of place
☐ Muscle spasms in neck
☐ Grinding sounds in neck
☐ Popping sounds in neck
☐ Arthritis in neck

ARMS AND HANDS:

☐ Pain in upper arm
☐ Pain in elbow
☐ Movement aggravated
☐ Tennis elbow
☐ Pain in forearm
☐ Pain in hands
☐ Pain in fingers
☐ Sensation of pins and needles in arms
☐ Sensation of pins and needles in fingers
☐ Numbness in arms (R-L)
☐ Fingers go to sleep
☐ Hands cold
☐ Swollen joints in fingers
☐ Sore joints in fingers
☐ Arthritis in fingers
☐ Loss of grip strength

SHOULDERS:

☐ Pain in shoulder joint (R-L)
☐ Pain across shoulders
☐ Bursitis (R-L)
☐ Arthritis (R-L)
☐ Can't raise arm
- ☐ above shoulder level
- ☐ over head

☐ Tension in shoulders
☐ Pinched nerve in shoulder (R- L)
☐ Muscle spasms in shoulders

MID BACK:

☐ Mid-back pain
☐ Location _____
☐ Pain between shoulder blades
☐ Sharp stabbing
☐ Dull ache
☐ Pain from front to back
☐ Muscle spasms
☐ Pain in kidney area

CHEST:

☐ Chest pain
☐ Shortness of breath
☐ Pain around ribs
☐ Breast pain
☐ Dimpled or orange peel breast
☐ Irregular heartbeat

ABDOMEN:

☐ Nervous stomach
☐ Foods can't eat
☐ Nausea
☐ Gas
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids

LOW BACK:

☐ Low back pain
☐ Upper lumhar
☐ Lower lumbar
☐ Sacroiliac
☐ Low back pain is worse when:
☐ Working
☐ Liftinng
☐ Stooping
☐ Standing
☐ Sitting
☐ Bending
☐ Coughing
☐ Lying down (sleeping)
☐ Walking
☐ Pain relieved when _____
☐ slipped disk
☐ Low back feels out of place
☐ Muscle spasms
☐ Arthritis

HIP, LEGS, AND FEET:

☐ Pain in buttocks
☐ Pain in hip joint
☐ Pain down leg
☐ Pain down both legs
☐ Knee pain
- ☐ inside
- ☐ outside

☐ Leg cramps
☐ Cramps in feet
☐ Pins and needles in legs
☐ Numbness of leg
☐ Numbness of toes
☐ Feet feel cold
☐ Swollen ankles
☐ Swollen feet

WOMEN ONLY:

☐ Menstrual pain _____ (where)
☐ Cramping
☐ Irregularity
☐ Cycle _____ days
☐ Birth control _____ (type)
☐ Hysterectomy
☐ Genital cancer _____
☐ Discharge
☐ Menopause
☐ Tumors
☐ Abortions
☐ Are you or do you think you are pregnant?

MEN ONLY:

☐ Urinary frequency _____
☐ Difficulty in starting
☐ Night urination
☐ Prostrate pain/swelling

GENERAL

☐ Nervousness
☐ Irritable
☐ Depressed
☐ Fatigue
☐ Generally feel run-down
☐ Normal sleep _____ hrs/night
☐ Loss of sleep _____ hrs/night
☐ Loss of weight _____ lbs
☐ Gain weight _____ lbs
☐ Coffee _____ cups/day
☐ Tea _____ cups/day
☐ Cigarettes _____ pack/day
☐ Other _____
☐ Diabetes
☐ Hypoglycemia

REMARKS: _____

Patient's Signature _____ Date _____

G101b

DISCLOSURE OF FEE'S/ PAYMENT POLICY

New Patient Exam, Consult & Adjustment	$120.00
New Patient Consultation only	$40.00
Adjustment	$50.00
Laser Therapy Treatments	$40.00
Pkg of 3 Treatments pre-paid	$90.00

I have read the above fee schedule and understand the cost of treatment with Dr. Hall. I understand I am responsible for payment at time of service.
I also understand that Dr. Hall operates a cash practice and will not bill any Insurance company but will provide a receipt with the necessary information for me to bill my insurance.

_____ _____

Signed Date