



DR. PATRICK J. WALSH
CHIROPRACTOR

CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip code _____
Telephone: (Home) _____ (Cell) _____ (Work) _____
Email _____ SS# _____ - _____ - _____
Age _____ Birthdate ____/____/____ Sex: M/F Status: M S W D No. of Children _____
Occupation _____ Employer _____ Address _____
Spouse's Name _____ Occupation _____
Person responsible for this account: Self/Spouse/Parent Referred by _____
What is your major complaint? _____

Other complaints _____ How long have you had this condition? _____
Have you had this or similar conditions in the past? Yes No Explain: _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? Yes No Constant Comes and goes
Is this condition interfering with your: Work Sleep Daily routine Other: _____
How long has it been since you felt really good? _____ List surgical operations: _____
Are you taking any medications? _____ What kind? _____
Any non-prescription drugs? _____ What kind? _____
Other doctors seen for this condition: MD DC DO Other _____

ACCIDENT INFORMATION:

Did your accident occur while at work? Yes No Were you involved in an auto accident? Yes No
Date _____ Time _____ Injury reported to employer? _____ Name of Supervisor _____
Description of Accident _____
Were you injured? _____ Were you hospitalized? _____ Where? _____ How long? _____
Have you had any other personal injury or accident? _____ When? _____
Do you have an attorney? Yes No Name & Address _____

Are you interested in: Relief Care Corrective Care? Do you want the doctor to choose for you? Yes No

I understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I decide to terminate my care and treatment, any fees or services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

PLEASE CHECK 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 bothers eyes
- Blurred vision
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK:

- Pain
 - Neck pain with movement
 - Forward
 - Backward
 - Turn to left
 - Turn to right
 - Bend to left
 - Bend to right
- Muscle spasms in neck
- Grinding sounds in neck

SHOULDERS:

- Pain in shoulder joint (R - L)
- Pain across shoulders
- Tension in shoulders
- Muscle spasms in shoulders

ARMS & HANDS:

- Upper arm pain
- Elbow pain
- Movement increases pain
- Pain in hands
- Pain in fingers
- Tingling in arms (R—L)
- Tingling in fingers (R—L)
- Fingers go to sleep
- Hands cold
- Joints swollen in fingers
- Arthritis in fingers
- Loss of grip strength

MID-BACK:

- Mid-back pain
- Pain between shoulder blades
- Sharp, stabbing pain
- Dull, achy pain
- Pain in kidney area

CHEST:

- Chest pain
- Rib pain
- Heartburn
- Shortness of breath
- Pain upon inspiration

ABDOMEN:

- Upset stomach
- Gas
- Constipation
- Diarrhea
- Pain after eating

LOW BACK:

- Low back pain
- Low back pain worse when:
 - bending
 - lifting
 - twisting
 - walking
 - sitting
 - standing
 - coughing
 - sleeping
- Muscle spasms

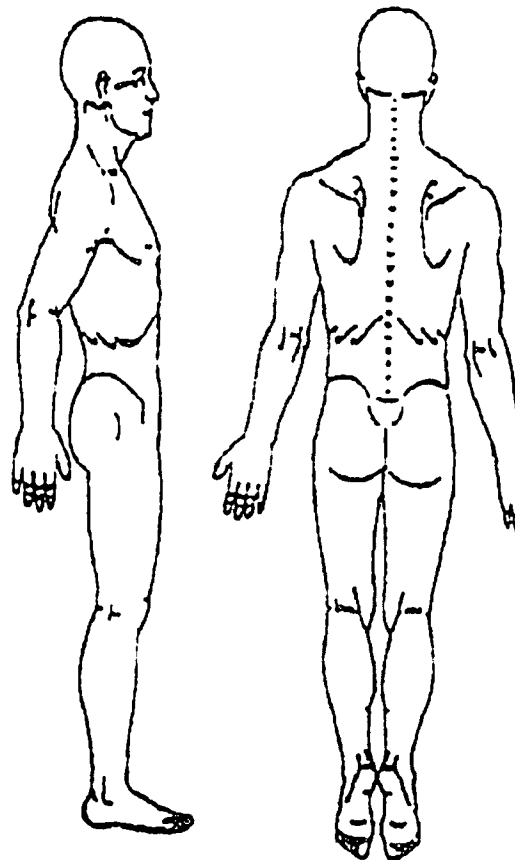
HIPS, LEGS, & FEET:

- Pain in hip joint (R—L)
- Pain in buttocks (R—L)
- Pain down leg (R—L)
- Knee pain
- Leg cramps
- Numbness of leg (R—L)
- Numbness of feet (R—L)
- Numbness of toes

GENERAL:

- Irritable
- Depressed
- Fatigue
- Loss of sleep
- Loss of weight _____ lbs
- Gain of weight _____ lbs
- Diabetes
- Other _____

CIRCLE AREA(S) OF COMPLAINT ON THE BODY DIAGRAM BELOW:



DOCTOR'S REMARKS:
