physicalhealth & Rehabilitation
Office of David Bennett D.C.

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CONFIDENTIAL PATIENT CASE HISTORY

Today's Date

NAME:_____ SOCIAL SECURITY #:_____ - _____ - _____

ADDRESS:_____ DATE OF BIRTH: _____ / _____ / _____ Age

SUITE / APT:_____ OCCUPATION:_____

CITY:_____ EMPLOYER:_____

STATE:_____ ZIP:_____ MARRIED / SINGLE: Spouse's Name?_____

PHONE HOME / CELL :_____ EMERGENCY CONTACT:_____

PHONE WORK:_____ EMERGENCY CONTACT PH:_____

E-MAIL:_____ WHO MAY WE THANK FOR REFERRING YOU TO US?

____ FRIEND / FAMILY (NAME) ?
____ WEB SITE ? _____ SEARCH ENGINE? ____ PHONE BOOK? _____

CHIEF COMPLAINT: _____

_____

Date of injury / illness

AUTO CRASH HISTORY

If your complaints are NOT auto related, please skip this section & continue to page 2.

Type of accident: Auto Truck Bus Taxi Van Motorcycle Other: _____

Where were you hit from?: Front Rear Left side Right side Top Other:_____

Were you the : Driver Passenger A pedestrian Riding a bike Other?_____

What did you strike? Head Rest Seat Window Door Dashboard
Steering wheel Ground Pole Other:_____

Did you / were you: Trip Mugged Slip-n-Fall Hit by falling object Other:_____

What body part was injured? Head Neck Upper back Low back Arms Legs Knees Elbows

Did you strike your: Head Neck Back Arms Legs Hands Feet

Were there any cuts or bruises? _____

Did you lose consciousness? Yes No If yes, for how long?_____

Were you taken to the hospital? Yes No If yes, which one?_____

Were you kept overnight (admitted)? Yes No If yes, for how long?_____

What treatment did you receive at the hospital? Medication Arm sling Neck collar Crutches Other:_____

Were X-rays taken? Yes No If yes, what was x-rayed?_____

CURRENT HEALTH STATUS

Do you have a family Medical Doctor? No Yes If yes, may we send him / her your treatment records? No yes

Dr's. Name
Address
Phone:

What doctors have you seen since this incident / illness?

	Name	Specialty	Date
1.			
2.			
3.			

What have you done at home for this condition? Nothing Ice / heat Rest Pain Medication

What professional treatment has been done thus far? None Neck Collar Physical Therapy Manipulation
Ice / Heat Braces Ultrasound Other:_____

What are your present symptoms? None Nausea Vomiting Dizziness Fainting Vision Problems
Nervousness Weakness in Arms / Legs Numbness in Arms / Legs

Pain in the: Head Neck Upper back Lower back Chest Abdomen Shoulders Arms Hands Legs Knees Feet

Difficulty with: Walking Bending Sitting Sleeping Moving of Arms / Legs Other:_____

Since this mishap / crash, have your symptoms become: Worse No improvement Better Slightly better Very much better

Were you on-the-job when this mishap / crash occurred? No Yes If yes, what were you doing at the time? _____

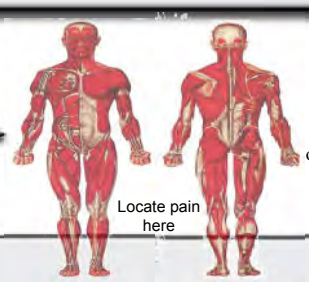
_____

Have you lost any work due to this mishap / crash? No Yes If yes, how many: Days? Weeks? Months?

Please indicate your degree of symptoms from "0" (no pain) to "10" (extreme pain).

No Pain	Headaches:	0	1	2	3	4	5	6	7	8	9	10
	Neck or Arms:	0	1	2	3	4	5	6	7	8	9	10
	Upper Back:	0	1	2	3	4	5	6	7	8	9	10
	Lower Back or Legs:	0	1	2	3	4	5	6	7	8	9	10

Ext Pain



Are you **LEFT** or **RIGHT** handed?

PAST HISTORY:

Have you ever been under chiropractic care **prior** to this complaint? No Yes If yes, when? _____

and for what condition? _____

Did you ever have a similar condition / accident? No Yes If yes, when? _____

Have you ever had any serious illness? No Yes If yes, please describe: _____

_____

Do you require medication? No Yes If yes, please identify type:_____

Have you ever had surgery? No Yes If yes, please list type and date below:

1.	
2.	
3.	

Please sign and date this document and acknowledge receiving a copy of your HIPAA Privacy Policy of this office.

Thank You!

Signature & Date