CASE HISTORY

Patient#_____ Date:_____ Phone#_____ Cell#_____
Name:_____ Date of Birth:_____ Age:_____ Sex:_____
Address_____ Marital Status: S M D W No. of Children_____
City/Zip_____ Spouses Name:_____
Occupation:_____ Employer:_____ Work#_____
Referred by:_____ Past Chiropractic Care: Yes / No If yes, Dr._____
Chief complaint:_____
Insurance Company:_____ Spouses Insurance:_____

Are your present injuries due to on-the-job injury? ___Yes___No
Have you made a report of your accident to your employer? ___Yes___No
Do you plan on turning it in on Workman's Compensation? ___Yes___No
Are you now or have been disabled (service or work)? ___Yes___No
If yes, When_____ How?_____

Race/Ethnicity
___American Indian or Alaska Native
___Asian
___Black or African American
___Native Hawaiian or Other Pacific Islander
___White
___Other Race
___Declined to specify

Please check all the following signs and symptoms that you are presently having.

General Symptoms
_____Headache
_____Fever
_____Chills
_____Night sweats
_____Fainting
_____Dizziness
_____Convulsions
_____Loss of sleep
_____Fatigue
_____Nervousness
_____Loss of weight
_____Numbness or pain in Arms/Hands/Legs
_____Allergies
_____Wheezing
_____Neuralgia

Gastro-Intestinal
_____Poor appetite
_____Poor digestion
_____Excessive hunger
_____Belching or gas
_____Nausea
_____Vomiting
_____Vomiting blood
_____Pain over stomach
_____Constipation
_____Diarrhea
_____Colon trouble
_____Hemorrhoids/piles
_____Liver problems
_____Jaundice
_____Gall Bladder trouble

Ear ,Nose, Throat
_____Poor vision
_____Crossed eyes
_____Pain in eyes
_____Deafness
_____Earache
_____Ear noises
_____Ear discharges
_____Nasal obstruction
_____Nose bleeds
_____Sore throat
_____Hoarseness
_____Hay fever
_____Asthma
_____Frequent colds
_____Enlarged thyroid
_____Tonsillitis
_____Sinus problems

Respiratory
_____Chronic cough
_____Spitting blood
_____Spitting phlegm
_____Chest pain
_____Difficulty breathing

Genitor-Urinary
_____Frequent urination
_____Painful urination
_____Blood in urine
_____Kidney infection
_____Bed wetting
_____Inability to control urine
_____Prostate trouble

Muscle & Joints
_____Weakness
_____Twitching
_____Stiff neck
_____Neck pain
_____Upper back pain
_____Mid back pain
_____Lower back pain
_____Spinal curvature
_____Swollen joints
_____Tremors
_____Foot problems
_____Painful tail bone
_____Pain between shoulders
_____Hernia

Cardio-Vascular
_____Rapid heart
_____Slow heart
_____High blood pressure
_____Low blood pressure
_____Pain over heart
_____Prev. heart problems
_____Swelling of ankles
_____Poor circulation
_____Varicose veins
_____Strokes

Skin or Allergies
_____Skin eruptions
_____Itching
_____Bruising easily
_____Dryness
_____Eczema
_____Boils
_____Sensitive skin
_____Hives or Allergies
_____Medicines

For Women Only
_____Painful periods
_____Excess flow
_____Irregular cycles
_____Hot flashes
_____Cramps or Backache
_____Miscarriage
_____Vaginal discharge
_____Pregnant at this time
_____Last Pap.
By Who:_____
Other:_____

Height:_____ Weight:_____

GINGELL CHIROPRACTIC CENTER, P.C.
9450 S. Main Street • Ste.106
Plymouth, Michigan 48170
(734)453-2447 • Fax (734)451-8664

Please turn the page for more information →

Habits

Smoking_____pks./day
Drinking_____Alcohol
Coffee _____cups/day

Exercise

None
Moderate
Daily

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother # of___	☐	☐	☐	☐	☐
Sister # of_____	☐	☐	☐	☐	☐

Have you had any of the following diseases?

_____Appendicitis	_____Anemia	_____Heart Disease	_____Arthritis
_____Pneumonia	_____Measles	_____Goiter	_____Epilepsy
_____Rheumatic Fever	_____Mumps	_____Influenza	_____Mental disorder
_____Polio	_____Chicken pox	_____Pleurisy	_____Lumbago
_____Tuberculosis	_____Diabetes	_____Alcoholism	
_____Whooping cough	_____Cancer	_____Venereal infection	

Operations & Procedures

Date_____Vaccinations	Date_____Tubes in Ears	Date_____Sinus	Date_____Tonsillectomy
Date_____Appendectomy	Date_____Hernia	Date_____Thyroid	Date_____Gall Bladder
Date_____Female Organs	Date_____Back Operation	Date_____Stomach	Date_____Rectal Surgery

Other (list type & date)_____

List any Accidents or Falls:

Car_____
Motorcycle_____Other:_____
Sports:_____School:_____
Broken Bones or Dislocations (Fractures):_____
Ever on Crutches?_____**Yes** _____**No** Why?_____
Have you ever had any spinal taps or spinal injections? _____**Yes**_____**No**
Were you ever knocked unconscious? _____**Yes**_____**No**
Have you ever had a lapse of Memory? _____**Yes**_____**No**
Have you ever had X-rays taken? _____**Yes**_____**No**
If yes, Why & When?_____
Do you suffer from any condition other than that which you are now consulting us?_____

List all over the counter and prescription medications you are taking:_____
_____

List any allergies :_____

Note: It is understood and agreed that I will be responsible for any fees not covered by my insurance, including any co-pays or deductibles. The x-ray negatives will remain the property of this office, being on file where they may be seen at any time during the course of treatment. (x-rays are not transferable).

Signature:_____

To avoid added bookkeeping expense, payment is expected at the time service is rendered unless other arrangements are made.

If you have any questions concerning this form or any others, please ask, we are happy to help!