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PATIENT CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME: _____ **DATE:** _____

SYMPTOMS AND PRESENT COMPLAINT:

Present Complaint / Reason for Seeking Care in this Office: _____

Major _____

Pain or Problem started when: (activity) _____ Date: _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

Does this pain shoot, radiate, or travel in your body? Y N Where? _____

Are you experiencing numbness or tingling in any area of your body? Y N Where? _____

Since it began this condition is: Same Better Worse

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? Y N Explain: _____

Is this condition interfering with: Work? _____ Sleep? _____ Routine? _____ Mental Attitude? _____

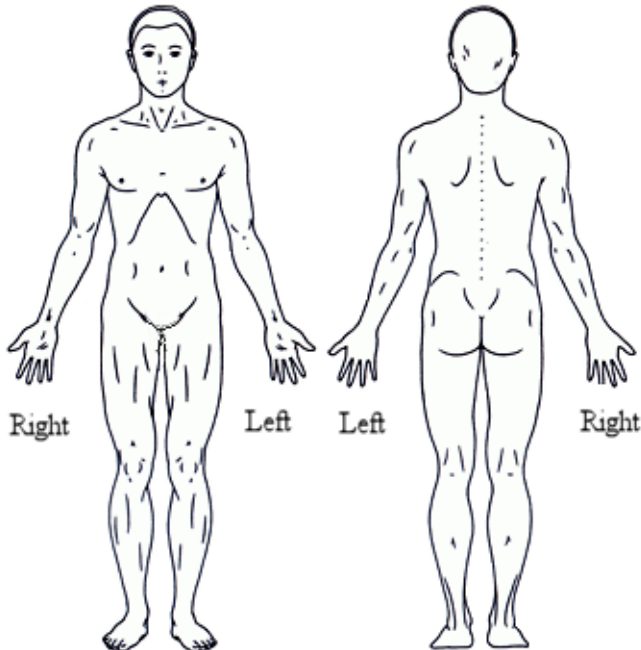
Other Doctors seen for this condition: _____ Treatments: _____

Any home remedies? _____

COMPLETE THESE DIAGRAMS

Please Circle where your level of pain is at today: **0** = (No Complaint/Pain) **10** = (Worst Possible Complaint/Pain)

0 1 2 3 4 5 6 7 8 9 10



Using the symbols below, mark on the pictures where you feel pain.

- | | |
|----------------|-----|
| Pain | PPP |
| Numbness | === |
| Dull Ache | OOO |
| Burning | XXX |
| Sharp/Stabbing | /// |
| Pins, Needles | +++ |
| Other _____ | ^^^ |

At birth, your nerve system is very vulnerable and can be easily injured through the birth process. The slips and falls of childhood and involvement in school sports can also cause injury. Nerve system damage at this early age can set the stage for illness, perhaps contributing to your current complaint.

CHILDHOOD HEALTH HISTORY:

Please circle for each of the following:

Regarding your Birth Process:

	Patient Comments (If answer is Yes)	Chiropractor's Comments
Was the delivery long/difficult?	Y N _____	_____
Forceps or extraction used?	Y N _____	_____
Cesarean/ C-Section?	Y N _____	_____
Breach/ cephalic?	Y N _____	_____
Home birth?	Y N _____	_____
Hospital birth?	Y N _____	_____
Mother given drugs during delivery?	Y N _____	_____
Was labor induced?	Y N _____	_____

Growth and Development/ Childhood:

Childhood illnesses?	Y N _____	_____
Ear infections/ Colic/ Asthma?	Y N _____	_____
Attention Deficit?	Y N _____	_____
Drugs, prescription, OTC, recreational?	Y N _____	_____
Surgery?	Y N _____	_____
Hospitalizations?	Y N _____	_____
Sports or other physical activities	Y N _____	_____
Injuries during sports?	Y N _____	_____
Auto accidents?	Y N _____	_____
Did you have other traumas?	Y N _____	_____
Did you ever break any bones?	Y N _____	_____

GENERAL HEALTH HISTORY:

Please circle for each of the following:

Did/do you smoke?	Y N _____	_____
Did/do you drink alcohol?	Y N _____	_____
Diet, do you eat healthy foods?	Y N _____	_____
Have you been in accidents/trauma?	Y N _____	_____
Did/do you take Drugs? (prescription, OTC, recreational)	Y N _____	_____
Hearing problems?	Y N _____	_____
Exercise regularly?	Y N _____	_____
Did/do you have occupational stress?	Y N _____	_____
Physical stress?	Y N _____	_____
Emotional/Mental stress?	Y N _____	_____
Hobbies/Sports injuries?	Y N _____	_____
Do you sleep well, hours of sleep?	Y N _____	_____
Sleeping posture?	O side O stomach O back	_____
Did you ever break any bones?	Y N _____	_____

OTHER SYMPTOMS:

Please mark any of the following conditions or symptoms that you have now or have experienced:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Pain in legs or feet |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Numbness in legs or feet |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Asthma | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Loss of smell or taste | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Stroke | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Jaw/TMJ problems | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Constipation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pain in hands or arms | <input type="checkbox"/> Menstrual cramps | |
| <input type="checkbox"/> Numbness in hands or arms | <input type="checkbox"/> Painful urination | |

MEDICAL INFORMATION:

Who is your family physician? _____ Group Name/ Office _____

Are you under medical care for any condition? _____

What medications are you currently taking and for what? _____

How long? _____ Any side effects? _____

Have you had surgery? Y N What? _____

When? _____ What side effects have you experienced from the surgery? _____

Females Only – Date last Menstrual Period began on _____ Are you possibly pregnant? _____

IS THERE A FAMILY HISTORY OF?

	Heart Disease	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____

HIPPA: Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **Optimum Health Chiropractic's** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **Optimum Health Chiropractic's** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Optimum Health Chiropractic**.

The Notice of Privacy Practices for **Optimum Health Chiropractic** is also provided on request at the main administration desk of this office. The Notice of Privacy Practices also describes my rights and **Optimum Health Chiropractic's** duties with respect to my protected health information.

Optimum Health Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient

Signature of Patient or Legal Guardian/Representative

Date