Dr. Nick Husser &
Dr. Janét Husser
Chiropractic Physicians

www.ohcwellness.com

4070 Center Road
Brunswick, OH 44212
Phone: (330) 460-5151
Fax: (844)255-1633

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:** ______________

Major Complaint:______________________________
____
____

O Sudden/Specific Date_______ O Gradual

What happened?______________________________
____

What positions, activities or movements make it Better?______________________________
____

What positions, activities or movements make it Worse?______________________________
____

What type of pain?
O Sharp O Dull O Achy O Burning
O Throbbing O Tingling O Numbness
O Stabbing Other______________________________

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

Where is your level of pain today?
0 = (No Pain) **10** = (Worst Possible Pain)
0 1 2 3 4 5 6 7 8 9 10

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

Percentage of day pain is present? ______________
0% = (Never) 100% = (Constant)

Other Doctors seen for this condition:
____

Other Treatments:______________________________
Any home remedies?______________________________

Major Complaint:______________________________
____
____

O Sudden/Specific Date_______ O Gradual

What happened?______________________________
____

What positions, activities or movements make it Better?______________________________
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NAME: ____ **DATE:** ____________________

HEALTH HISTORY: Please circle for each of the following:

Did/do you smoke? Y N __________________________ ___________________
Have you been in accidents/trauma? Y N __________________________ ___________________
____
Exercise regularly? Y N __________________________ ___________________
Mental / Physical
OCCUPATIONAL stress? Y N __________________________ ___________________
Mental / Physical
HOME 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 ___________________
Have you ever received Chiropractic Care? Yes No If yes, when______________________________

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

O Headaches
O Lights bother eyes
O Ringing in ears
O Dizziness
O Loss of balance
O Loss of memory
O Loss of smell or taste
O Sinus problems
O Allergies
O Jaw/TMJ problems
O Neck pain
O Neck stiffness
O Tension
O Pain in hands or arms
O Numbness in hands or arms

O Cold hands
O Shoulder pain
O Pain between shoulders
O Chest pains
O Asthma
O Shortness of breath
O Heart Attack
O High blood pressure
O Stroke
O Heartburn/Reflux
O Stomach upset
O Diarrhea
O Constipation
O Menstrual cramps
O Painful urination

O Low back pain
O Pain in legs or feet
O Numbness in legs or feet
O Cold feet
O Irritability
O Fatigue
O Joint swelling
O Fever
O Weight loss
O Cancer
O Diabetes
O Menopause
O Other____________________

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NAME: ____ **DATE:** _____________________

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?______________________ Surgery side effects?______________________________________
____
Have you broken any bones? Y N
What?____

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	O	O	O
Mother's side	O	O	O

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______________________

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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 Date

____ ____________________
Legal Guardian/Representative Date