PATIENT CASE HISTORY

T.J. NUGENT DC, PLC

NAME:	Email:	DATE:
ADDRESS:	CITY/STATE:	APT #

ZIP CODE:	Home Phone:( ) Work:( ) Cell:( )	DATE OF BIRTH:	AGE:

□ MARRIED □ WIDOWED □ SINGLE □ DIVORCED	□ MALE □ FEMALE	NO. OF CHILDREN:	OCCUPATION:

DO YOU HAVE HEALTH INSURANCE? (If yes, please give company name, address & phone number):
□ YES Company:
□ NO Address: Phone: ( )

INSURED'S NAME:	INSURED'S ADDRESS/ PHONE: (If same as patient, leave blank)
INSURED'S EMPLOYER:	ID # GROUP/ POLICY #

SOCIAL SECURITY #	REFERRED BY:	HAVE YOU HAD CHIROPRACTIC CARE BEFORE? □ YES WHERE/ WHEN ? □ NO

WHAT IS YOUR MAJOR COMPLAINT?	JOB DESCRIBTION:
_____	_____
_____	_____
_____	_____

ARE YOU ON MEDICARE? □ YES, MEDICARE # _____ □ NO	ARE YOU ON MEDICAID? □ YES, MEDICAID# _____ □ NO

INDICATE IF YOU ARE HERE FOR CARE BECAUSE OF: □ ON THE JOB INJURY □ AN AUTO ACCIDENT □ A HOME INJURY	DATE INJURED:_____ INSURANCE CO:_____ ATTORNEY'S NAME:_____ ATTORNEY'S PHONE:_____ ATTORNEY'S ADDRESS:_____

HAVE YOU EVER HAD ANY FALLS, AUTO ACCIDENTS OR INJURIES? □ YES □ NO	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

HAVE YOU EVER HAD SURGERY? □ YES □ NO	MONTH, YEAR	TYPE OF SURGERY	COMMENTS

ARE YOU PRESENTLY TAKING MEDICATION? □ YES □ NO	DRUG	DOSES PER DAY	LENGTH OF TIME TAKING

2931 MANOR DRIVE MIDLAND, MI 48640 (989)-835-8330
FAX: (989)-835-4906 E-MAIL: tjnugentdc@yahoo.com

WWW.TJNUGENTDC.COM

26. PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY AT THIS TIME

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Loss of smell
- ☐ Allergies
- ☐ Hay fever
- ☐ Asthma
- ☐ Loss of taste
- ☐ Tightness of throat
- ☐ Throat inflammation
- ☐ Thyroid trouble
- ☐ Twitching of face
- ☐ Loss of memory
- ☐ Fatigue
- ☐ Depression
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred Vision
- ☐ Light bothers eye
- ☐ Neck pain
- ☐ Muscle spasms in neck
- ☐ Grating in neck
- ☐ Tightness of shoulder muscles
- ☐ Pain in shoulders & arms
- ☐ Pins & needles in arms & hands
- ☐ Cold hands
- ☐ Chest pains
- ☐ Shortness of breath
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Stomach trouble
- ☐ Nerves & nervousness
- ☐ Inner tension
- ☐ Irritability
- ☐ Cold sweats
- ☐ Gall bladder trouble
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Low back pain
- ☐ Mid-back pain
- ☐ Dizziness
- ☐ Numbness
- ☐ Constipation
- ☐ Kidney trouble
- ☐ Menstrual cramps & pain
- ☐ Menstrual irregularity
- ☐ Diabetes
- ☐ Cancer
- ☐ Sleeping problems
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Pinched nerves in back
- ☐ Pins and needles in legs
- ☐ Swollen ankles
- ☐ Cold feet
- ☐ Pains in legs and feet

DO NOT WRITE BELOW THIS LINE

CONSENT FOR CHIROPRACTIC CARE OF MINOR CHILD

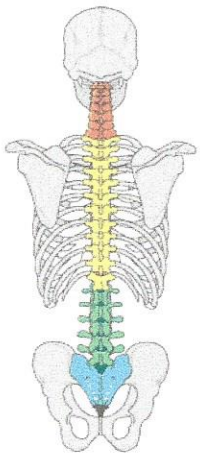
I herby authorize Dr. T.J. Nugent and whoever he may designate as his assistants to administer Chiropractic care as he deems necessary to my child.

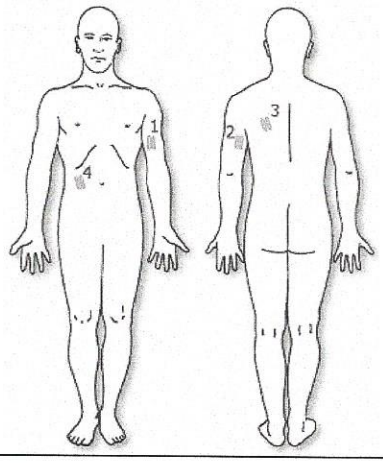
Child's Name: _____

_____ _____

Signature of Parent or Guardian Signature of witness

Dated at the office of **T.J. Nugent DC, PLC** _____





Doctor's Use Only

Comments: _____

Work restriction ☐Yes ☐No
Cervical support ☐Yes ☐No
Lumbar support ☐Yes ☐No

No work from _____ to _____

Height _____ Weight _____ B.P. _____

- ☐George's test
- ☐Adson's test
- ☐Derifield test
- ☐Cervical flexion
- ☐Cervical extension
- ☐Cerv lat flex (l)
- ☐Cerv lat flex (r)
- ☐Cerv rotation (l)
- ☐Cerv rotation (r)
- ☐Thoracolumbar flex
- ☐TL Extension
- ☐TL lat flex (l)
- ☐TL lat flex (r)
- ☐TL rotation (l)
- ☐TL rotation (r)