INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____/____/_____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name**: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Gender:** Male Female **Social Security #**:_____

Home: _____ **Mobile:** _____ **Work:** _____

Email: _____

Preferred Method of Contact: Text Email Phone - *Home, Mobile, or Work* Other: _____

***Referred By:** *(Name)* _____

Family Friend Co-Worker Doctor Other: _____

Race & Ethnicity: *(Choose up to 2)*

African American or Black
American Indian or Alaskan Native
Asian
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
White
Decline

Preferred Language:

English
Spanish
Other: _____
Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship:

Child Parent Spouse Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

No Auto Work Other: _____

Will we be working with insurance? No Yes *(Details)*

Primary: _____ *ID#:* _____

Secondary: _____ *ID#:* _____

Where would you like statements sent?

Self Other *(Details below)*

Name: _____

Address: _____

Phone: _____ *Email:* _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: _____ **Secondary Complaints:** _____

_____ _____

_____ _____

When did it start? ____/____/_____ **What happened?** _____

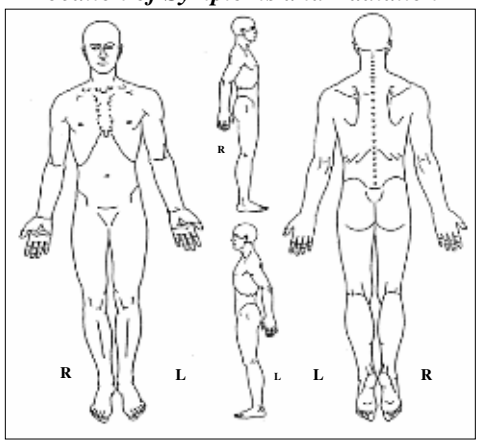
_____

Which daily activities are being affected by this condition? _____

_____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain T__ Tender
N __ Numb H__ Hypoesthesia
S __ Spasm

Grade Intensity/Severity:

None (0/10)
Mild (1-2/10)
Mild-Moderate (2-4/10)
Moderate (4-6/10)
Moderate-Severe (6-8/10)
Severe (8-10/10)

Frequency:

Off & On
Constant

Quality:

Sharp
Stabbing
Burning
Achy
Dull
Stiff & Sore
Other: _____

Does it radiate?

No Yes *(Please indicate on drawing)*

Improves with:

Ice
Heat
Movement
Stretching
OTC Medications: _____
Other: _____

Worsens with:

Sitting
Standing/Walking
Lying Down/Sleeping
Overuse/Lifting
Other: _____

Previous Treatment:

None
Chiropractor _____
Medical Doctor _____
Physical Therapy _____
ER/Urgent Care _____
Orthopedic _____
Other: _____

Previous Diagnostic Testing:

None
X-rays _____
MRI _____
CT _____
Other: _____

Women:** ***Are you pregnant?

No *Last Menstrual Period:* ___/___/____
Yes *Due date:* ___/___/____

Present Illness Comments:

_____
_____
_____
_____
_____
_____

Prescription Medications & Supplements: None

Yes *(List – Name, dosage, frequency)* _____

_____
_____
_____
_____
_____

Allergies to Medications: No known drug allergies

Yes *(List - Name and reaction)*_____

_____
_____
_____
_____
_____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- Asthma
- Autoimmune Disorder (*Type*) _____
- Blood Clots
- Cancer (*Type*) _____
- CVA/TIA (stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: _____

_____

_____

Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____

_____

Surgeries: *(If yes, provide type & surgery date)*

- Cancer _____
- Orthopedic
  - Shoulder – R / L _____
  - Elbow/Forearm – R / L _____
  - Wrist/Hand – R / L _____
  - Hip – R / L _____
  - Knee – R / L _____
  - Ankle/Foot – R / L _____
- Spinal Surgery
  - Neck: _____
  - Back: _____
- Other: _____

_____

_____

Medical History Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

Unknown Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: Single Married Divorced Other

Children: None 1 2 3 4 Other:_____

Student Status: Full Student Part Student Non-Student

Highest level of Education: High School College Grad.

Post Grad. Other: _____

Employed: No Yes (*Occupation*) _____

Dominant Hand: Right Left Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* _____

Every Day Some Days Former Never

Alcohol Use:

Every Day Weekly Occasionally Never

Caffeine Use:

Coffee Tea Energy Drinks Soda Never

Exercise frequency:

Daily 3-4xs/week 2-3xs/week Rarely Never

Social History Comments: _____

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
Fever
Fatigue
Other: ______________________
None in this Category

Musculoskeletal:
Joint Pain/Stiffness/Swelling
Muscle Pain/Stiffness/Spasms
Broken Bones_________________
Other: ______________________
None in this Category

Neurological:
Dizziness or Lightheaded
Convulsions or Seizures
Tremors
Other: ______________________
None in this Category

Psychiatric: *(Mind/Stress)*
Nervousness/Anxiety
Depression
Sleep Problems
Memory Loss or Confusion
Other: ______________________
None in this Category

Genitourinary:
Frequent or Painful Urination
Blood in Urine
Incontinence or Bed Wetting
Painful or Irregular Periods
Other: ______________________
None in this Category

Gastrointestinal:
Loss of Appetite
Blood in Stool or Black Stool
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other: ______________________
None in this Category

Cardiovascular & Heart:
Chest Pains/Tightness
Rapid or Heartbeat Changes
Swelling of Hands, Ankles, or Feet
Other: ______________________
None in this Category

Respiratory:
Difficulty Breathing
Cough
Other: _________________
None in this Category

Eyes & Vision:
Eye Pain
Blurred or Double Vision
Sensitivity to Light
Other: ______________________
None in this Category

Head, Ears, Nose, & Mouth/Throat:
Frequent or Recurrent Headaches
Ear - Ache/Ringing/Drainage
Hearing Loss
Sensitivity to Loud Noises
Sinus Problems
Sore Throat
Other: ______________________
None in this Category

Endocrine:
Infertility
Recent Weight Change
Eating Disorder
Other: ______________________
None in this Category

Hematologic & Lymphatic:
Excessive Thirst or Urination
Cold Extremities
Swollen Glands
Other: ______________________
None in this Category

Integumentary: *(Skin, Nails, & Breasts)*
Rash or Itching
Change in Skin, Hair, or Nails
Non-healing Sores or Lesions
Change of Appearance of a Mole
Breast Pain, Lump, or Discharge
Other: ______________________
None in this Category

Allergic/Immunologic:
Food Allergies
Environmental Allergies
Other: ______________________
None in this Category

Review of Systems Comments:

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ____ Date______________________