

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 Home Phone Other: _____

*Referred By: (Name) _____

Family Friend Co-Worker Doctor Other: _____

Race & Ethnicity: (Choose up to 2)

Preferred Language:

African American or Black

English

American Indian or Alaskan Native

Spanish

Asian

Other: _____

Hispanic or Latino

Decline

Native Hawaii or Other Pacific Islander

White

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?

Where would you like statements sent?

No Auto Work Other: _____

Self Other (Details below)

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

Name: _____

Primary: _____ ID#: _____

Address: _____

Secondary: _____ ID#: _____

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: _____

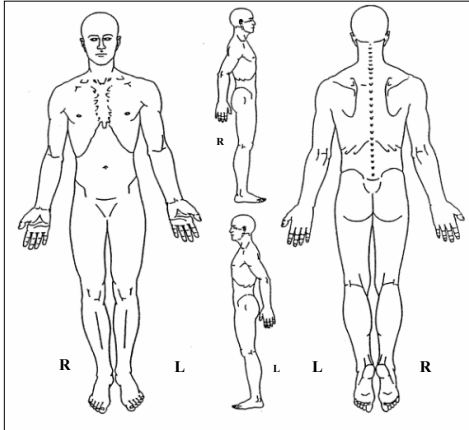
Secondary Complaints: _____

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

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:

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

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: _____

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:

Injuries:

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

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

- Unknown Unremarkable

Family History Comments:

	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								

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: Single Married Divorced Other

Caffeine Use:

- Coffee Tea Energy Drinks Soda Never

Children: None 1 2 3 4 Other: _____

Student Status: Full Student Part Student Non-Student

Exercise frequency:

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

Highest level of Education: High School College Grad.

Post Grad. Other: _____

Social History Comments: _____

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

REVIEW OF SYSTEMS

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Many of the following conditions respond to Chiropractic and Acupuncture 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.

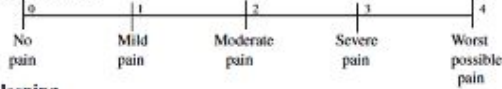
Patient or Guardian Signature _____ Date _____

Functional Rating Index

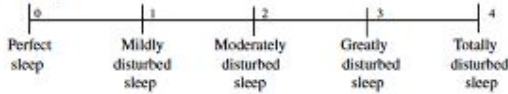
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

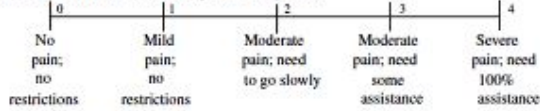
1. Pain Intensity



2. Sleeping



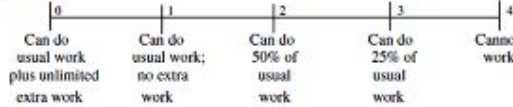
3. Personal Care (washing, dressing, etc.)



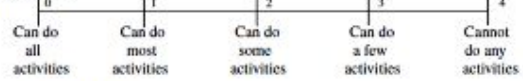
4. Travel (driving, etc.)



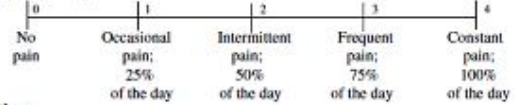
5. Work



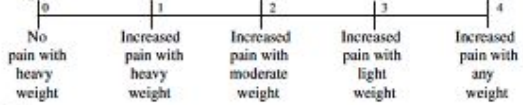
6. Recreation



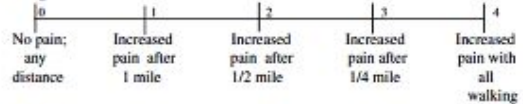
7. Frequency of pain



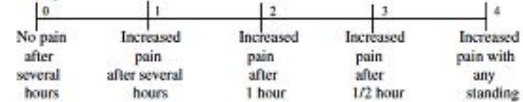
8. Lifting



9. Walking



10. Standing



Name _____

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Signature _____

Total Score _____

Date _____