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)*

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaii 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:* _____

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

Patient or Guardian Signature _____ Date _____

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?** _____

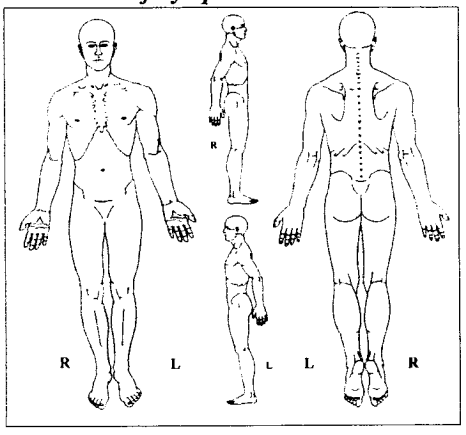
_____

Which daily activities are being affected by this condition? _____

_____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain
N __ Numb
S __ Spasm
T __ Tender
H __ Hypoesthesia

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)* _____

_____

_____

_____

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

Patient or Guardian Signature _____ Date_____

Print Name: *(First MI Last)* _____

Account No: _____

REVIEW OF SYSTEMS

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_____

Print Name: *(First MI Last)* _____

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: _____

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

Patient or Guardian Signature _____ Date_____

Print Name: *(First MI Last)* _____