

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: _____

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: _____

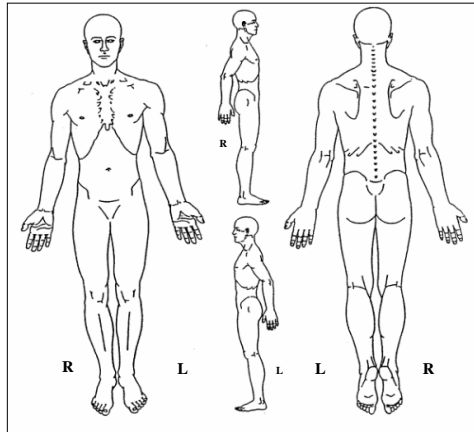
Secondary Complaints: _____

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: _____

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

	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

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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

Respiratory:

- Difficulty Breathing
- Cough
- Other: _____
- None in this Category

Review of Systems Comments:

Musculoskeletal:

- Joint Pain/Stiffness/Swelling
- Muscle Pain/Stiffness/Spasms
- Broken Bones _____
- Other: _____
- None in this Category

Eyes & Vision:

- Eye Pain
- Blurred or Double Vision
- Sensitivity to Light
- Other: _____
- None in this Category

Neurological:

- Dizziness or Lightheaded
- Convulsions or Seizures
- Tremors
- 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

Psychiatric: *(Mind/Stress)*

- Nervousness/Anxiety
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: _____
- None in this Category

Endocrine:

- Infertility
- Recent Weight Change
- Eating Disorder
- 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

Hematologic & Lymphatic:

- Excessive Thirst or Urination
- Cold Extremities
- Swollen Glands
- 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

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

Cardiovascular & Heart:

- Chest Pains/Tightness
- Rapid or Heartbeat Changes
- Swelling of Hands, Ankles, or Feet
- Other: _____
- None in this Category

Allergic/Immunologic:

- Food Allergies
- Environmental Allergies
- Other: _____
- None in this Category

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

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

1.) Pain Intensity **1** **2** **3** **4**

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain
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2.) Sleeping

Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed
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3.) Personal Care (washing, dressing, etc.)

No Pain; No Restrictions	Mild Pain; No Restriction	Moderate Pain; Go Slowly	Moderate Pain; Some Assistance	Severe Pain; 100% Assistance
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4.) Travel (driving, etc.)

No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
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5.) Work

Usual Work +Extra	Usual Work, No Extra	50% of Usual Work	25% of Usual Work	Cannot Work
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6.) Recreation

All Activities	Most Activities	Some Activities	Few Activities	No Activities
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7.) Frequency of Pain

No Pain	Occasional (25%)	Intermittent (50%)	Frequent (75%)	Constant (100%)
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8.) Lifting

No Pain with Heavy Weight	Increased Pain with Heavy Weight	Increased Pain with Moderate Weight	Increased Pain with Light Weight	Increased Pain with Any Weight
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9.) Walking

No Pain with Any Distance	Increased Pain after 1 Mile	Increased Pain after ½ Mile	Increased Pain after ¼ Mile	Increased Pain after Any Distance
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10.) Standing

No Pain with Any Time	Increased Pain after Several Hours	Increased Pain after 1 Hour	Increased Pain after ½ Hour	Increased Pain after Any Time
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Total _____ (/4, X10) = Functional Rating Score _____%

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

0%-20%-Minimal, 20%-40%-Moderate, 40%-60%Severe, 60%-80% - Crippled, 80%-100% Bed Bound