

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

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: _____

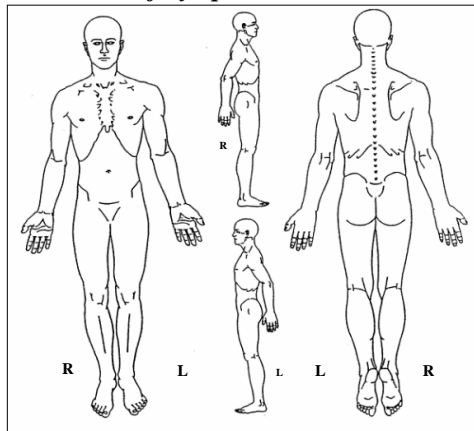
Secondary Complaints: _____

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

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

	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: _____

