INTRODUCTION PATIENT CASE HISTORY

Today's Date:/	-			
PATIENT INFORMATION				
Name: (First MI Last)			Preferred Name:	
Address:		y:	State:	Zip:
Date of Birth:	Gender: Male Female	Social Security #:		
Home:	Mobile:	Work:		
Email:				
Preferred Method of Contact:	☐ Text ☐ Email ☐ ☐	Phone - Home, Mobile, or We	ork 🗆 Oth	ner:
*Referred By: (Name)				
•	☐ Co-Worker ☐ Doctor ☐	Other		
Race & Ethnicity: (Choose up to 2) Preferred L		Language:		
☐ African American or Black	□ Englis	h		
☐ American Indian or Alaskaı	n Native	sh		
☐ Asian	☐ Other:			
☐ Hispanic or Latino	□ Declin	e		
☐ Native Hawaiian or Other P	acific Islander			
□ White				
☐ Decline				
EMERGENCY CONTACT INFORMATION				
Name: (First MI Last)		Primary Care Phys	sician:	
Home: Mobile:				
Relationship:				
-	se			
•				
FINANCIAL INFORMATION				
Is today's visit the result of an a	Where would you li	ike statements	sent?	
□ No □ Auto □ Work □ Other:		□ Self □ Oth	er (Details below)	
Will we be working with insuran	nce? No Yes (Details)	Name:		
Primary:		Address:		
Secondary	ID#·	Phone:	Email: _	

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

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HISTORY OF PRESENT ILLNESS

Major Complaint:		Secondary Complaints:		
When did it start?/ Wh	at happened?			
Which daily activities are being affected b	by this condition?			
	Major Com	<u>PLAINT</u>		
Location of Symptoms and Radiation	Quality:	Previous Treatment:		
	☐ Sharp	□ None		
	☐ Stabbing	☐ Chiropractor		
	☐ Burning	☐ Medical Doctor		
	☐ Achy	☐ Physical Therapy		
	□ Dull	□ ER/Urgent Care		
GERA AGES	☐ Stiff & Sore	Orthopedic		
	☐ Other:	Other:		
	Does it radiate?	Previous Diagnostic Testing:		
R L L R	□ No □ Yes (Please inc			
	Improves with:	□ X-rays		
P Pain	☐ Ice	□ MRI		
S _ Spasm	☐ Heat	□ CT		
Grade Intensity/Severity:	☐ Movement	☐ Other:		
□ None (0/10)	☐ Stretching	*Women: Are you pregnant?		
☐ Mild (1-2/10)	☐ OTC Medications:			
☐ Mild-Moderate (2-4/10)	☐ Other:			
Moderate (4-6/10) Worsens with:		Present Illness Comments:		
☐ Moderate-Severe (6-8/10)	☐ Sitting			
□ Severe (8-10/10)	☐ Standing/Walking			
Frequency:				
□ Off & On	☐ Overuse/Lifting			
☐ Constant	☐ Other:			
Prescription Medications & Supplements	:	Allergies to Medications: □ No known drug allergies		
☐ Yes (List – Name, dosage, frequency)		Yes (List - Name and reaction)		
				

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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.) **Hospitalizations:** (Non-surgical with Date) Medical History Comments: Illnesses: Asthma ☐ Autoimmune Disorder (*Type*) _____ ☐ Blood Clots **Surgeries:** (If yes, provide type & surgery date) \Box Cancer (T_{ype}) ☐ CVA/TIA (stroke) Cancer Diabetes Orthopedic ☐ Migraine Headaches Shoulder – R / L _____ Osteoporosis Elbow/Forearm – R / L _____ ☐ Other: _____ Wrist/Hand – R / L _____ Hip - R / L $Knee-R/L___$ Ankle/Foot - R / L**Injuries:** ☐ Spinal Surgery ☐ Back Injury Neck: □ Broken Bones Back: ☐ Head Injury ☐ Other: ☐ Neck Injury □ Falls ☐ Other: Family History (Please mark X to all that apply and use comments to elaborate.) Unremarkable ☐ Unknown Family History Comments: Sibling2 Father Child3 Gender 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: Children:** \square None \square 1 \square 2 \square 3 \square 4 \square Other:____ ☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never **Student Status:** □ Full Student □ Part Student □ Non-Student **Exercise frequency: Highest level of Education:** □ High School □ College Grad. \square Daily \square 3-4xs/week \square 2-3xs/week \square Rarely \square Never □ 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

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REVIEW OF SYSTEMS

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Many of the following conditions respond to chiropractic treatment.

Are you <u>currently</u> 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 Psychiatric: (Mind/Stress) □ Nervousness/Anxiety	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	
 □ Depression □ Sleep Problems □ Memory Loss or Confusion □ Other: □ None in this Category 	Endocrine: Infertility Recent Weight Change Eating Disorder Other:	
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:	None in this Category Hematologic & Lymphatic:	
☐ Chest Pains/Tightness ☐ Rapid or Heartbeat Changes ☐ Swelling of Hands, Ankles, or Feet ☐ Other: ☐ None in this Category	Food Allergies Environmental Allergies Other: None in this Category	
I have answered these questions to the best of Patient or Guardian Signature	my knowledge and certify them to be true and correct	fDate

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