

# 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*

Account No: \_\_\_\_\_

# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: \_\_\_\_\_

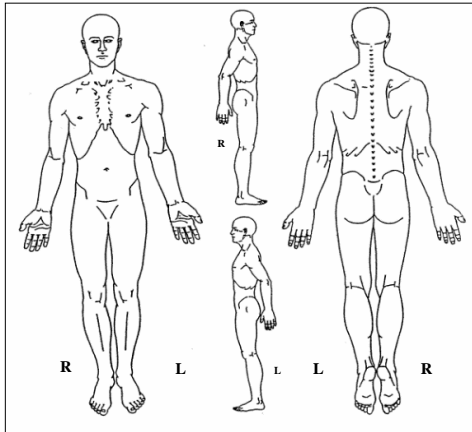
Secondary Complaints: \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 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:

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

## 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

Many of the following conditions respond to chiropractic 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:*

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

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_