Introduction Patient Case History

Date: _____

PATIENT INFORMATION

Name: *(First MI Last)*_____ **Preferred Name:**_____

Street: _____ **Apt.:** _____

City: _____ **State:** _____ **Zip:** _____

Social Security #: _____ **Date of Birth**: _____ **Gender**: □ M □ F

Martial Status: [ ] S [ ] M [ ] W [ ] D [ ] O **Spouse**: _____

Children: □ None □ 1 □ 2 □ 3 □ 4 □ Other: _____

Who Referred you to this office? *(Name)* _____

Language: English / Spanish / Indian / Japanese / Chinese / French / German / Russian / Other _____

Race/Ethnicity: White / American Indian or Alaska Native/ Asian / Native Hawaiian/Other Pacific Islander / African American / Hispanic or Latino / Decline to Answer

CONTACT INFORMATION

Home Ph: _____ **Work Ph:** _____ **Cell Ph:** _____

Cell Carrier: _____ **Email Hm:** _____

Email Wk: _____ **Preferences:** Home Ph / Work Ph / Cell Ph / Email Hm / Email Wk / Postal Mail

Emergency Contact: _____ **Phone:** _____

Primary Physician: _____ **Phone:** _____

Student Status: □ Full Student □ Part Student □ Non-Student

Highest level of Education: □ High School □ College Grad. □ Post Grad. □ Other: _____

Employed: □ No □ Yes *(Details below)*

Occupation: _____ **Employer:** _____

Employers Address: _____

Street City State Zip

FINANCIAL INFORMATION

Is today's visit the result of an accident?

□ No □ Auto □ Work □ Other: _____

Will we be working with insurance? □ No □ Yes (Details)

A copy of your insurance card[s] will be made, in addition, please complete the information requested below:

Primary: _____ *ID#:* _____

Secondary: _____ *ID#:* _____

Where would you like statements sent?

□ Self □ Other (Details below)

Other than Self: - (Relationship) _____

Full Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS ***(Please describe)***

Describe Major Complaint: _____ **Secondary Complaints:** _____

_____ _____

_____ _____

_____ _____

When did it start? ___/ ___ / ___ **What happened?**_____

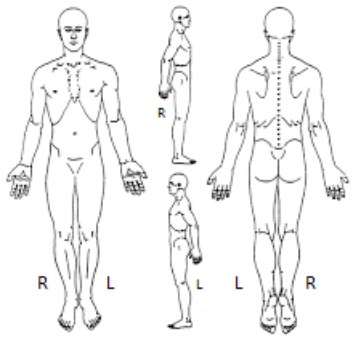
_____

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: _____
_____
_____

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	Sibling4	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

Do you live: □ Alone □ With Spouse □ With _____

Dominant Hand: □ Right □ Left □ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* _____

□ Every day □ Some Days □ Former □ None

Drug Use:

□ None □ Recreational User □ Addiction

Alcohol Use:

□ None □ Casual □ Moderate □ Heavy

□ Drinks Wine □ Drinks Beer

Caffeine Use: □ No □ Yes

How often:

□ < 3 drinks/day □ 3-6 drinks/day □ > 6 drinks/day

What kind of Caffeine?

□ Coffee □ Tea □ Energy Drinks □ Soda

Exercise Frequency:

□ Never □ Daily □ Weekly □ Walks

□ Runs □ Swims

Social History Comments:

_____
_____
_____
_____

Are you *currently* experiencing any of these symptoms? (Check all that apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
□ Recent Weight Change
□ Fever
□ Fatigue
□ *None in this Category*

Musculoskeletal:
□ Low Back Pain
□ Mid Back Pain
□ Neck Pain
□ Arm Problems _____
□ Leg Problems _____
□ Painful Joints
□ Stiff/Swollen Joints
□ Sore/Weak Muscles or Joints
□ Muscle Spams/Cramps
□ Broken Bones _____
□ Other: _____
□ *None in this Category*

Neurological:
□ Numbness or tingling sensations
□ Loss of Feeling
□ Dizziness or Light Headed
□ Frequent or Recurrent Headaches
□ Convulsions or Seizures
□ Tremors
□ Stroke
□ Headaches
□ Have you ever had a head injury?
□ Ever been in an auto accident?
□ Other: _____

Mind/Stress:
□ Nervousness
□ Sleep Problems
□ Memory Loss or Confusion
□ Other: _____
□ None in this Category

Genitourinary:
□ Sexual Difficulty
□ Kidney Stones
□ Burning / Painful Urination
□ Change in force / strain with urinatio
□ Frequent Urination
□ Blood in Urine
□ Incontinence or Bed Wetting
□ Other: _____
□ *None in this Category*

Gastrointestinal:
□ Loss of Appetite
□ Blood in Stool
□ Change in Bowel Movements
□ Nausea or Vomiting
□ Abdominal Pain
□ Frequent Diarrhea
□ Constipation
□ Eating Disorder
□ Other: _____
□ *None in this Category*

Cardiovascular & Heart:
□ Chest Pains
□ Rapid or Heartbeat change
□ Swelling of Hands, Ankles or Feet
□ Heart Problems
□ Blood Pressure Problems

BLOOD PRESSURE PROBLEMS:
Are you currently being treated? □**Yes** □ **No**
_____
IF YES, Who is treating you?
□ Other: _____
□ *None in this Category*

Respiratory:
□ Difficulty Breathing
□ Coughing Blood
□ Persistent Cough
□ Asthma or Wheezing
□ Lung Problems
□ Other: _____
□ *None in this Category*

Ears, Nose and Throat:
□ Bleeding gums/ Mouth Sores
□ Bad Breath or Bad Taste
□ Dental Problems
□ Swollen Throat or Voice Change
□ Swollen Glands in Neck
□ Ringing in the Ears
□ Ear - Ache/Ringing/Drainage
□ Sinus / Allergy Problems
□ Nose Bleeds
□ Hearing Loss
□ Other: _____
□ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
□ Thyroid Problems
□ Diabetes
□ Excessive Thirst or Urination
□ Cold Extremities
□ Heat or Cold Intolerance
□ Change in hat or glove size
□ Dry Skin
□ Glandular or Hormone Problem
□ Swollen Glands
□ Anemia
□ Easily Bruise or Bleed
□ Phlebitis
□ Transfusion
□ Immune System Disorder
□ Other: _____
□ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
□ Rash or Itching
□ Change in Skin Color, Hair, or Nails
□ Non-healing Sores or Lesions
□ Change of appearance of a mole
□ Breast Pain, Lump, or Discharge
□ Other: _____
□ *None in this Category*

Eyes and Vision:
□ Wear Contacts/Glasses
□ Blurred or Double Vision
□ Glaucoma
□ Eye disease or Injury
□ Other: _____
□ *None in this Category*

Women Only:
□ Infertility
□ Painful or Irregular Periods
□ Vaginal Discharge
□ Other: _____
□ *None in this Category*
Pregnancies with Outcome & Date
_____
_____

Allergic/ Immunologic:
□ Food Allergies
□ Environmental Allergies
□ Other: _____
□ *None in this Category*

Comments: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with health care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

Morris Family Chiropractic Center, LLC
230 South Street (Blair House) Suite 2
Morristown, NJ 07960
(973.455.1660)

Have you ever had acupuncture before? □ Yes □ No

What is the problem that brought you here today? _____

Have you eaten today? □ Yes □ No

If yes, at what time was your last meal? _____

When did this problem first appear? _____

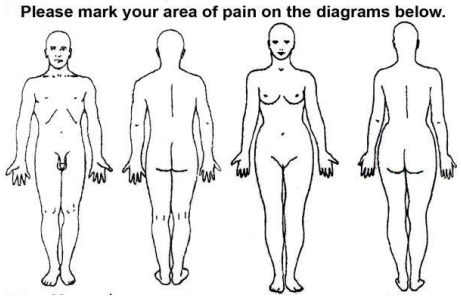
Has there been anything that has ever been able to change your problem in any way? □ Yes □ No

If yes, please describe _____

Is it the problem □ Constant □ Off and On

If applicable, does the problem ever move? *(For example, pain or spasms that occur in different joints or muscles at different times)* □ Yes □ No

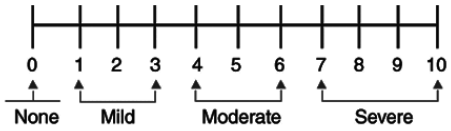
Please mark your area of pain on the diagrams below.



Do you have a history of chronic pain? □ Yes □ No

Are you experiencing pain right now? □ Yes □ No

If yes, what number best describes your pain? _____



0-10 Pain Intensity Numeric Rating Scale (NRS)

What is the frequency of the pain? □ Continuous □ Intermittent

What makes your pain better? (*Please check all that apply)*

☐ Heat ☐ Pressure ☐ Movement ☐ Cold ☐ Massage ☐ Rest ☐ Other _____

Is your illness/problem affected by seasonal changes? □ Yes □ No

If yes, please describe _____

Are there other problems you would like addressed? □ Yes □ No

If yes, please describe _____

_____

Do you have trouble falling asleep? □ Yes □ No **Number of hours you sleep at night** _____

Do you wake up frequently? ☐ Yes ☐ No

If yes, when? _____

Do you wake up very early and are unable to go back to sleep? □Yes □ No

Describe your bowel habits: □ Regular (Times per day: _____) □ Constipation □ Diarrhea

If you suffer from constipation:

How do you feel immediately after moving your bowels? □ Better □ Worse

How many days pass before you move your bowels? _____

If you suffer from diarrhea:

Does it occur early in the morning when you first wake up? □ Yes □ No

Does your rectum burn as the stool exits? □ Yes □ No

How many episodes of diarrhea do you have per day? _____

Do you regularly experience abdominal pain? □ Yes □ No

If yes, what makes it better? (*Please check all that apply*)

□ Heat □ Eating □ Rest □ Massage
□ Cold □ Not Eating □ Movement □ Other_____

Do you have any emotional difficulties? (*Please check all that apply*)

□ Anxiety □ Mania □ Depression Seasonal
□ Mood Swings □ Affective Disorder □ Panic Attacks

How would you rate your ability to concentrate/maintain focused thinking, and have clarity of thought? *(Please check one choice)* □ Excellent □ Good □ Fair □ Poor

How many times a day do you urinate per day? _____

Color of Urine: □ Clear □ Pale Yellow □ Dark Yellow
Volume of Urine: □ Scant □ Normal □ Abundant

How would you rate your appetite? *(Please check one choice)*

□ Excessive □ Moderate/Good □ Poor

Do you crave sweets? □ Yes □ No

Do you crave other foods? □ Yes □ No

If yes, what type? _____

Do you get headaches often? □ Yes □ No

If yes, **is it always in the same location?** □ Yes □ No

If yes, **where?** _____

Do you ever experience dizziness? □ Yes □ No

Are you often thirsty? □ Yes □ No

What temperature do you prefer your drinks? *(Please check one choice)*

□ Cold □ Room Temperature □ Warm

Do you often feel cold? □ Yes □ No

If yes, where? (*Please check all that apply*)

□ Hands / Feet □ Limbs □ Entire Body □ Other _____

Describe the degree to which you sweat: □ Very Little □ Average □ Excessive

Do you sweat at night? □ Yes □ No

Do you exercise? □ Yes □ No

If yes, how often? _____

What do you do? _____

How would you rate your energy level?

□ Excellent □ Good □ Fair □ Poor □ Other_____

Describe your diet:

Number of vegetable portions eaten daily: _____

Number of meat product portions eaten daily: _____

Number of dairy product portions eaten daily: _____

Number of caffeine containing products eaten daily: _____

Number of whole grain product portions eaten daily: _____

Have you had your lymph nodes removed? □ Yes □ No

*If yes, please describe*_____

_____

Do you have any infectious diseases? □ Yes □ No

*If yes, please describe*_____

_____

WOMEN ONLY

Is there a chance that you could be pregnant? □ Yes □ No

Are your menstrual cycles: □ Regular □ Irregular □ Early □ Late

How many days is your cycle from 1st day of bleeding to last day before next period? _____

How many days does your period last? _____

Age of Menarche (first menstrual cycle): _____

Is your menstrual flow: □ Heavy □ Normal □ Light

Is the blood: □ Normal □ Purplish □ Dark □ Light

Does your menstrual blood contain clots? □ Yes □ No

If yes, **what color are the clots?** □ Bright Red □ Dark in Color

Are they larger than a quarter? □ Yes □ No

Do you have vaginal discharge? □ Clear □ White and Thin □ Yellow and Thick

Do you have itching or soreness of the vagina? □ Yes □ No

Do you generally experience mood swings? □ Yes □ No

Use the choices below to describe how they are around the time of your menses. *(Please check one)*

□ Better □ Worse □ Same □ Not Applicable

Number of pregnancies: _____ Number of miscarriages: _____ **Number of abortions**: _____

Do you have symptoms that only appear prior to your period? □ Yes □ No

If yes are they: □ Sore/Swollen Breasts □ Mood Swings □ Headaches

□ Bloating □ Anger □ Sadness □ Other _____

I understand that Acupuncture care at Morris Family Chiropractic Center, LLC is separate from chiropractic care. I understand that J. Bartley Martinez, DC, MAc may NOT be an acupuncture provider for my insurance carrier and no guarantee of reimbursement from my insurance carrier has been made by this office. My signature below indicates that I clearly understand that this office may not have an acupuncture relationship with my insurance carrier and that, regardless of my insurance company's policies, I am responsible to pay for my Acupuncture visits on the day of service.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Parent/Guardian's Signature

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 number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc)

0	1	2	3	4
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

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
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

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____

PRINTED

Total Score _____

_____

Signature

_____

Date

excel.funct