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's Name**: _____

Children: □ None □ 1 □ 2 □ 3 □ 4 □ Other List Names and ages: _____

_____

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:** _____

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)***

What is your primary pain/complaint: _____

Secondary pains/complaints: _____

What date did you first notice your primary pain/complaint?_____

Did something cause your primary pain/complaint to begin? _____

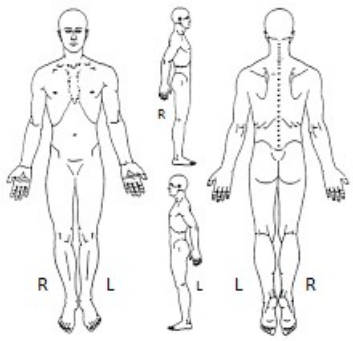
_____

Which daily activities are being affected by this condition? _____

_____

PRIMARY 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:

_____

_____

_____

_____

_____

If you saw any doctor or healthcare professional for your primary pain/complaint, please list their names and what they did, or prescribed, for you:

Doctor/Health Practitioner's Name's:	**What they did or prescribed for you:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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: _____
_____
_____

Prescription Medications and Supplements:
(*list name, dosage, frequency)*

_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medications:

□ No known drug allergies
□ Yes *(List- Name and reaction)*

_____
_____
_____
_____
_____
_____

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:

Does anyone in your family suffer with the same Condition? Yes ____ No____

Whom?_____
_____
_____

Any hereditary conditions the doctor should be aware of? Yes____ No____

If Yes, What? _____
_____

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

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 _____

Activities Discomfort Scale

For each of the following activities please place a check in the column that best describes how much pain the activities presently cause, on the average (does not include unusual or prolonged activity).

Activities	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running/Jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing/Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

Additional Comments:

Patient Name:_____ Patient Signature:_____

Examiner:_____ Date:_____ Score:_____