INTRODUCTION PATIENT CASE HISTORY

TODAY'S DATE: _____ **PATIENT NO:** _____

PATIENT INFORMATION

NAME: _____ **PREFERRED NAME:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME: _____ **MOBILE:** _____ **MOBILE CARRIER:** _____ **WORK:** _____

EMAIL: _____ **GENDER:** M / F **MARITAL STATUS:** SINGLE/MARRIED/OTHER

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____

STUDENT STATUS: FULL STUDENT/PART STUDENT/NON-STUDENT **EMPLOYED:** Y / N

ETHNICITY: HISPANIC OR LATINO/NON-HISPANIC OR LATINO/DECLINE **PREFERRED LANGUAGE:** ENGLISH / DECLINE / OTHER _____

RACE: ASIAN / AFRICAN AMERICAN / AMERICAN INDIAN OR ALASKAN / OTHER / NATIVE HAWAII OR PACIFIC ISLANDER / WHITE / DECLINE

***REFERRED BY: (NAME)** _____ FAMILY/ FRIEND/ CO-WORKER/ DOCTOR/ OTHER SOURCE

EMERGENCY CONTACT INFORMATION

NAME: _____ **PRIMARY CARE PHYSICIAN:** _____

HOME: _____ **MOBILE:** _____ **DOCTOR'S PHONE:** _____

RELATIONSHIP: CHILD / PARENT/ SPOUSE/ OTHER: _____

FINANCIAL INFORMATION

INSURANCE **WORKER'S COMP** **SELF-PAY (CASH)** **PERSONAL INJURY/AUTO** **OTHER (EXPLAIN)** _____

INSURANCE NAME: _____ **POLICY #:** _____ **GROUP:** _____

WHO IS RESPONSIBLE FOR PAYMENT? **SELF / OTHER:** _____

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED.

HEALTH HISTORY – PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED.

MEDICATIONS AND SUPPLEMENTS:

ALLERGIES TO MEDICATIONS: NONE

NAME	REACTION

CURRENT PRESCRIBED MEDICATIONS: NONE

NAME	DOSAGE	FREQUENCY	METHOD

SURGERIES/INJURY/TRAUMA/ HOSPITALIZATIONS: NONE

DATE	DESCRIBE

FAMILY HEALTH HISTORY: N/A

LIST *RELEVANT* MAJOR HEALTH PROBLEMS OF FIRST DEGREE RELATIVES:

PROBLEM	PARENT M/F	SIBLING B/S	CHILD S/D

SMOKING / TOBACCO USE: EVERY DAY/ SOME DAYS/ FORMER/ NEVER

HABIT	TYPE	AMOUNT	YR. STARTED
SMOKING			
TOBACCO			
ALCOHOL			
CAFFEINE			
REC. DRUGS			

NUMBER OF FALLS IN THE LAST 24 MONTHS: _____

WERE YOU INJURED? Y OR N

PATIENT CASE HISTORY

DESCRIBE #1 COMPLAINT TODAY: _____

DESCRIBE ANY SECONDARY COMPLAINT: _____

DESCRIBE WHEN AND HOW THIS BEGAN:

_____

GRADE INTENSITY / SEVERITY OF COMPLAINT: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8)/ Severe (8-10)

QUALITY OF THE COMPLAINT / PAIN: Sharp / Stabbing / Burning / Achy / Dull / Stiff / Sore / Other: _____

HOW FREQUENT IS THE COMPLAINT PRESENT? Off & On / Constant

DOES THIS COMPLAINT RADIATE / SHOOT TO ANY AREAS OF YOUR BODY? Yes / No

Head- Base of Skull / Forehead / Sides- Temple R / L / Both *Leg* – Hip / Thigh / Knee / Calf / Foot / Toes R / L / Both

Arm – Across Shoulder / Elbow/ Hand/ Fingers R / L / Both *Other Area*- _____

DOES ANYTHING MAKE THE COMPLAINT BETTER? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

DOES ANYTHING MAKE THE COMPLAINT WORSE? Sit / Stand/ Walk / Lying / Sleep / Overuse / Other: _____

WHICH DAILY ACTIVITIES ARE BEING AFFECTED BY THIS CONDITION? _____

FOR THIS CURRENT CONDITION, HAVE YOU:

RECEIVED ANY OTHER TREATMENT? None / DC / MD / PT / Massage / ER / Other: _____ Where? _____

HAD ANY DIAGNOSTIC TESTING? X-rays / MRI / CT / Other: _____ When and Where? _____

PATIENT NO: _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS? (CHECK ALL THE APPLY)
MANY OF THE FOLLOWING CONDITIONS RESPOND TO CHIROPRACTIC AND ACUPUNCTURE TREATMENT.

GENERAL: (CONSTITUTIONAL)
- ☐ RECENT WEIGHT CHANGE
- ☐ FATIGUE
- ☐ FEVER
- ☐ 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 SPASMS/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
- ☐ HAVE YOU EVER HAD A HEAD INJURY?
- ☐ EVER BEEN IN AN AUTO ACCIDENT?
- ☐ OTHER: _____
- ☐ NONE IN THIS CATEGORY

MIND/STRESS:
- ☐ NERVOUSNESS
- ☐ DEPRESSION
- ☐ SLEEP PROBLEMS
- ☐ MEMORY LOSS OR CONFUSION
- ☐ OTHER: _____
- ☐ NONE IN THIS CATEGORY

GENITOURINARY:
- ☐ SEXUAL DIFFICULTY
- ☐ KIDNEY STONES
- ☐ BURNING/PAINFUL URINATION
- ☐ CHANGE IN FORCE/STRAIN W URINATION
- ☐ FREQUENT URINATION
- ☐ BLOOD IN URINE
- ☐ INCONTINENCE OR BED WETTING
- ☐ OTHER: _____

COMMENTS:
_____

GASTROINTESTINAL:
- ☐ LOSS OF APPETITE
- ☐ CHANGE IN BOWEL MOVEMENTS
- ☐ BLOOD IN STOOL
- ☐ PAINFUL BOWEL MOVEMENTS
- ☐ NAUSEA OR VOMITING
- ☐ ABDOMINAL PAIN
- ☐ FREQUENT DIARRHEA
- ☐ CONSTIPATION
- ☐ NONE IN THIS CATEGORY
- ☐ OTHER: _____

CARDIOVASCULAR & HEART:
- ☐ CHEST PAINS
- ☐ RAPID OR HEARTBEAT CHANGES
- ☐ BLOOD PRESSURE PROBLEMS
- ☐ SWELLING OF HANDS, ANKLES, OR FEET
- ☐ HEART PROBLEMS
- ☐ OTHER: _____
- ☐ NONE IN THIS CATEGORY

RESPIRATORY:
- ☐ DIFFICULTY BREATHING
- ☐ PERSISTENT COUGH
- ☐ COUGHING BLOOD
- ☐ ASTHMA OR WHEEZING
- ☐ LUNG PROBLEMS
- ☐ 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

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

SKIN AND BREASTS:
- ☐ RASH OR ITCHING
- ☐ CHANGE IN SKIN COLOR
- ☐ CHANGE IN HAIR OR NAILS
- ☐ NON-HEALING SORES
- ☐ CHANGE OF APPEARANCE OF A MOLE
- ☐ BREAST PAIN
- ☐ BREAST LUMP
- ☐ BREAST DISCHARGE
- ☐ OTHER: _____
- ☐ NONE IN THIS CATEGORY

WOMEN ONLY:
ARE YOU PREGNANT?
- ☐ **YES - DUE DATE** ___/____/____
- ☐ **NO - LAST MENSTRUAL PERIOD** ___/____/____
- ☐ INFERTILITY
- ☐ PAINFUL OR IRREGULAR PERIODS
- ☐ VAGINAL DISCHARGE
- ☐ OTHER: _____
- ☐ NONE IN THIS CATEGORY

PREGNANCIES:

DATE	OUTCOME

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 CHIROPRACTIC CARE, DIAGNOSTIC TESTING, AND/OR THERAPEUTIC SERVICES, IN ACCORDANCE WITH THIS STATE'S STATUTES.

PATIENT OR GUARDIAN SIGNATURE _____ **DATE**_____

TREATING DOCTOR SIGNATURE _____ **DATE**_____