INTRODUCTION PATIENT CASE HISTORY

Today's Date:_____

PATIENT INFORMATION

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

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

Home:(_____)_____ **Mobile:**(_____)_____ **Work:**(_____)_____

Email: _____ **Marital Status:** Single / Married / Other

Social Security #:_____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed: Y / N**

Preferred Language: English / Decline / Other: _____

***Referred By: (Name):** _____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

MEDICAL HISTORY

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 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
__ 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: _____
__ None in this Category

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

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

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

Gastrointestinal:
__ Loss of Appetite
__ Blood in Stool
__ Change in Bowel Movements
__ Painful Bowel Movements
__ Nausea or Vomiting
__ Abdominal Pain
__ Frequent Diarrhea
__ Constipation
__ 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:
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____

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 chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe any Secondary Complaints: _____

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? **No / Yes** *(Describe)* _____

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? *(Describe)* _____

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?** _____

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 Medications & Supplements: *NONE*

Name	Dosage	Frequency	Method

Past Health History: *(Please list any past…)*

Number of Falls in the last 24 months: _____ **Injuries?** Y or N

Surgeries: *NONE*

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: *NONE*

Date	Describe

Family Health History: *N/A*

List *relevant* major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education: High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	