

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Name: (Last, First MI) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Mobile Carrier: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Gender: M / F Marital Status: Married / Other / Single

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student Status: Full Student / Part Student / Non-Student  Employed Employer: \_\_\_\_\_

\*Referred By: \_\_\_\_\_

Ethnicity: Hispanic or Latino / Other

Preferred Language: \_\_\_\_\_

Race: Asian / African Am. / Am. Indian or Alaskan Native /  
Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

## EMERGENCY CONTACT INFORMATION

Full 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 (please explain): \_\_\_\_\_

### PRIMARY INSURANCE

### SECONDARY INSURANCE

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relation to Insured: Self / Spouse / Parent / Child / Other

Relation to Insured: Self / Spouse / Parent / Child / Other

*Other than Self:*

*Other than Self:*

Insured's Name: \_\_\_\_\_ Gender: M / F

Insured's Name: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Who is responsible for payment? Self / Other - (Relationship) \_\_\_\_\_

*Other than Self:*

Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Patient No: \_\_\_\_\_

# PATIENT CASE HISTORY



## HISTORY OF CURRENT CONDITION

**Describe Major Complaint:** \_\_\_\_\_

**Began When?** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Describe how this began:** \_\_\_\_\_

**Grade Intensity/Severity of Complaint:** None / Mild / Moderate / Severe / Very Severe

**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 previous Surgery or Interventions in this area?** (Describe) \_\_\_\_\_

• **Taken any Medications?** OTC / Prescriptions \_\_\_\_\_

• **Had any diagnostic testing?** X-rays / MRI / CT / Other: \_\_\_\_\_ **When and Where?** \_\_\_\_\_

**Describe any Secondary Complaints:** \_\_\_\_\_

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



### Medications:

**Allergies to Medications:** NONE (List) \_\_\_\_\_

**Current Medications:** NONE

(Already have a list? We can make a copy.) \_\_\_\_\_



### Past Health History: (Please list any past...)

**Surgeries – Date, Type, and Reason:** NONE

**Major Injuries/Traumas:** NONE \_\_\_\_\_

**Major Hospitalizations:** NONE \_\_\_\_\_

**Patient No:** \_\_\_\_\_



### Family Health History: (Please mark N/A if not relevant.)

**List relevant major health problems of immediate relatives:**

**Deaths in immediate family:** (Cause and at what Age?)



### Social and Occupational History:

**Level of Education Completed:** \_\_\_\_\_

High School / Some College / College Grad. / Post Grad. / Other

**Lifestyle:** (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

### Habits:

Cigarettes – (#/day) \_\_\_\_\_

Alcohol – (amount/day) \_\_\_\_\_

Coffee/Tea – (cups/day) \_\_\_\_\_

Rec. Drugs (List) \_\_\_\_\_

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
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
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:
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

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 with Outcome & Date:

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 No: