

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

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

SECONDARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
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.) _____

ⓐ 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?)

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

Surgeries - Date, Type, and Reason: NONE

ⓐ 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) _____

Patient No: _____

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 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:

Blank lines for recording pregnancy outcomes and dates.

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

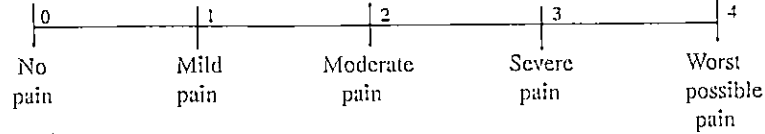
Patient No:

Functional Rating Index

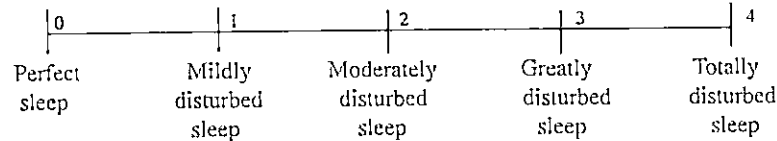
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back 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.

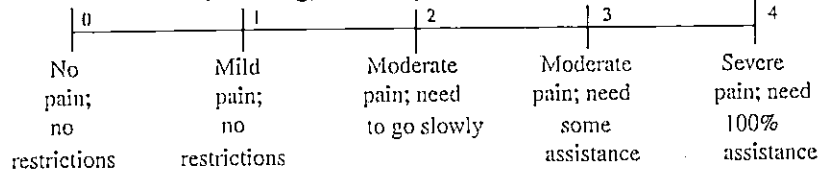
1. Pain Intensity



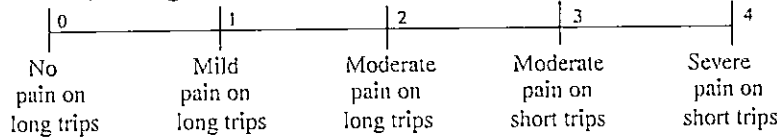
2. Sleeping



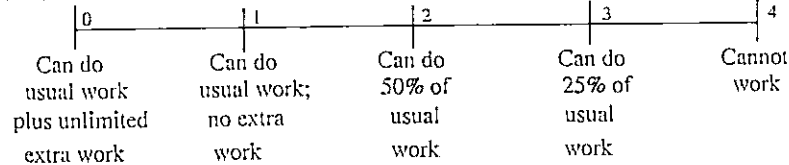
3. Personal Care (washing, dressing, etc.)



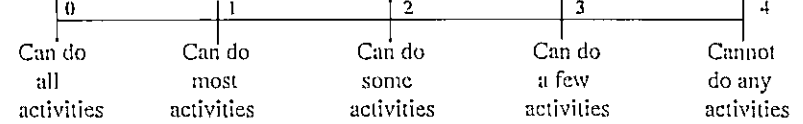
4. Travel (driving, etc.)



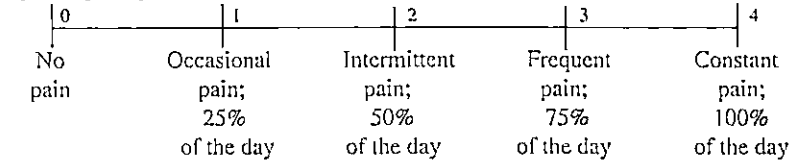
5. Work



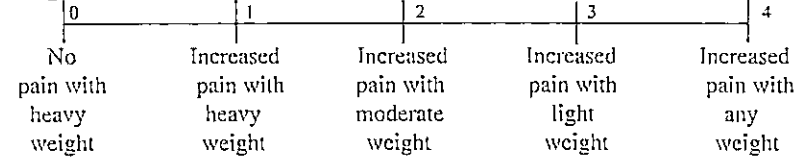
6. Recreation



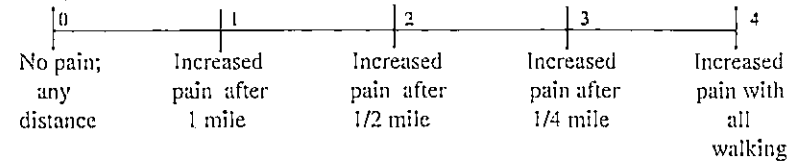
7. Frequency of pain



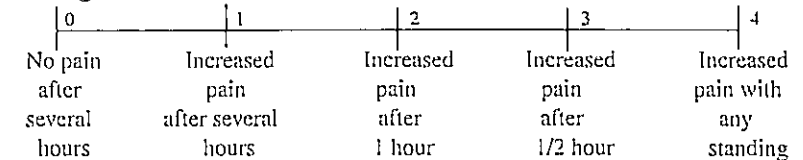
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Total Score _____

Signature _____

Date _____