

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____/____/____

PATIENT INFORMATION

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

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

Date of Birth: _____ Gender: Male Female Social Security #: _____

Home: _____ Mobile: _____ Work: _____

Email: _____

Preferred Method of Contact: Text Email Phone - Home, Mobile, or Work Other: _____

*Referred By: (Name) _____

Family Friend Co-Worker Doctor Other: _____

Race & Ethnicity: (Choose up to 2)

Preferred Language:

African American or Black

English

American Indian or Alaskan Native

Spanish

Asian

Other: _____

Hispanic or Latino

Decline

Native Hawaiian or Other Pacific Islander

White

Decline

EMERGENCY CONTACT INFORMATION

Name: (First MI Last) _____

Primary Care Physician: _____

Home: _____ Mobile: _____

Doctor's Phone: _____

Relationship:

Child Parent Spouse Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

No Auto Work Other: _____

Where would you like statements sent?

Self Other (Details below)

Will we be working with insurance? No Yes (Details)

Name: _____

Primary: _____ ID#: _____

Address: _____

Secondary: _____ ID#: _____

Phone: _____ Email: _____

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

Account No: _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: _____

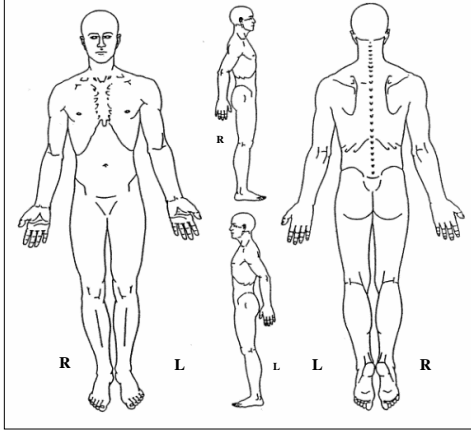
Secondary Complaints: _____

When did it start? ___/___/___ **What happened?** _____

Which daily activities are being affected by this condition? _____

MAJOR 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:

Prescription Medications & Supplements: None

Yes (List - Name, dosage, frequency) _____

Allergies to Medications: No known drug allergies

Yes (List - Name and reaction) _____

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: _____

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: _____

Medical History Comments:

Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: _____

FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- Unknown Unremarkable

Family History Comments:

| | Mother | Father | Sibling1 | Sibling2 | Sibling3 | Child1 | Child2 | Child3 |
|----------------------------|--------|--------|----------|----------|----------|--------|--------|--------|
| Gender | F | M | | | | | | |
| Age at death (if Deceased) | | | | | | | | |
| Aneurysms | | | | | | | | |
| CVA (Stroke) | | | | | | | | |
| Cancer | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Disease | | | | | | | | |
| Hypertension | | | | | | | | |
| Other Family History | | | | | | | | |

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: Single Married Divorced Other

Children: None 1 2 3 4 Other: _____

Student Status: Full Student Part Student Non-Student

Highest level of Education: High School College Grad.

Post Grad. Other: _____

Employed: No Yes (Occupation) _____

Dominant Hand: Right Left Ambidextrous

Smoking/Tobacco Use: If current smoker, amount = _____

- Every Day Some Days Former Never

Alcohol Use:

- Every Day Weekly Occasionally Never

Caffeine Use:

- Coffee Tea Energy Drinks Soda Never

Exercise frequency:

- Daily 3-4xs/week 2-3xs/week Rarely Never

Social History Comments: _____

REVIEW OF SYSTEMS

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Many of the following conditions respond to chiropractic treatment.

Are you **currently** experiencing any of these symptoms? (Please select all that apply and use comments to elaborate.)

Constitutional: (General)

- Fever
- Fatigue
- Other: _____
- None in this Category

Musculoskeletal:

- Joint Pain/Stiffness/Swelling
- Muscle Pain/Stiffness/Spasms
- Broken Bones _____
- Other: _____
- None in this Category

Neurological:

- Dizziness or Lightheaded
- Convulsions or Seizures
- Tremors
- Other: _____
- None in this Category

Psychiatric: (Mind/Stress)

- Nervousness/Anxiety
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: _____
- None in this Category

Genitourinary:

- Frequent or Painful Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Painful or Irregular Periods
- Other: _____
- None in this Category

Gastrointestinal:

- Loss of Appetite
- Blood in Stool or Black Stool
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: _____
- None in this Category

Cardiovascular & Heart:

- Chest Pains/Tightness
- Rapid or Heartbeat Changes
- Swelling of Hands, Ankles, or Feet
- Other: _____
- None in this Category

Respiratory:

- Difficulty Breathing
- Cough
- Other: _____
- None in this Category

Eyes & Vision:

- Eye Pain
- Blurred or Double Vision
- Sensitivity to Light
- Other: _____
- None in this Category

Head, Ears, Nose, & Mouth/Throat:

- Frequent or Recurrent Headaches
- Ear - Ache/Ringing/Drainage
- Hearing Loss
- Sensitivity to Loud Noises
- Sinus Problems
- Sore Throat
- Other: _____
- None in this Category

Endocrine:

- Infertility
- Recent Weight Change
- Eating Disorder
- Other: _____
- None in this Category

Hematologic & Lymphatic:

- Excessive Thirst or Urination
- Cold Extremities
- Swollen Glands
- Other: _____
- None in this Category

Integumentary: (Skin, Nails, & Breasts)

- Rash or Itching
- Change in Skin, Hair, or Nails
- Non-healing Sores or Lesions
- Change of Appearance of a Mole
- Breast Pain, Lump, or Discharge
- Other: _____
- None in this Category

Allergic/Immunologic:

- Food Allergies
- Environmental Allergies
- Other: _____
- None in this Category

Review of Systems Comments:

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

Functional Rating Index (FRI)
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 how your condition is right now and place an X on the number when you are at your best.**

1. Pain Intensity

0 1 2 3 4
None Mild Moderate Severe Worst

2. Sleeping

0 1 2 3 4
None Mild Moderate Severe Worst

3. Personal Care (Washing, Dressing, Etc)

0 1 2 3 4
None Mild Moderate Severe Worst

4. Travel

0 1 2 3 4
None Mild Moderate Severe Worst

5. Work

0 1 2 3 4
None Mild Moderate Severe Worst

6. Recreation

0 1 2 3 4
None Mild Moderate Severe Worst

7. Frequency of Pain

0 1 2 3 4
None Mild Moderate Severe Worst

8. Lifting

0 1 2 3 4
None Mild Moderate Severe Worst

9. Walking

0 1 2 3 4
None Mild Moderate Severe Worst

10. Standing

0 1 2 3 4
None Mild Moderate Severe Worst

NAME: _____

DATE: _____

SIGNATURE: _____

TOTAL SCORE: _____ (For Doctors Use Only)