INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

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

Patient SSN: _____ **Gender:** M / F **Date of Birth:** _____

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

Home: _____ **Mobile:** _____ **Work:** _____
Primary Phone Number: ☐ Home ☐ Mobile ☐ Work

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

Employer: _____ **Student Status:** Full-Time / Part-Time / Non-Student

***Referred By:** _____

**This section is optional.*

Ethnicity: Hispanic or Latino / Other

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

Preferred Language: _____

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Relationship to Patient:** _____

Address: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

FINANCIAL INFORMATION

☐ Insurance ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Worker's Comp ☐ Other: (Explain) _____

PRIMARY INSURANCE

Insured's Name: _____

Insured's DOB: _____

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

SECONDARY INSURANCE

Insured's Name: _____

Insured's DOB: _____

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

Who is responsible for payment? Self / Other – (Relationship) _____
Other than Self:
Full Name: _____ **Phone:** _____

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

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*:**

Current Medications: ***NONE***

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

_____

_____

_____

Allergies to Medications: ***NONE*** *(List)* _____

_____

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

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

_____

_____

_____

Major Injuries/Traumas: ***NONE*** _____

_____

_____

_____

Major Hospitalizations: ***NONE*** _____

_____

_____

_____

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 – Never / Former / Occasionally / Daily: _____ *(#/day)*

Alcohol – Never / Occasionally / Weekends / Daily: _____ *(#/day)*

Coffee/Tea – Never / Occasionally / Daily: _____ *(cups/day)*

Rec. Drugs – *(List)* _____

REVIEW OF SYSTEMS

Are you *currently* experiencing any of these symptoms? *(Check ALL that apply)*
Many of the following conditions respond to Chiropractic treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joint
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones _____
- ☐ Other: _____

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: _____

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in Force/Strain with Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat Changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____

Eyes & Vision:
- ☐ Wear Contacts/Glasses
- ☐ Blurred or Double Vision
- ☐ Glaucoma
- ☐ Eye Disease or Injury
- ☐ Other: _____

Ears, Nose & Throat:
- ☐ Bleeding Gums/Mouth Sores
- ☐ Bad Breath or Bad Taste
- ☐ Dental Problems
- ☐ Swollen Throat or Voice Change
- ☐ Swollen Glands in Neck
- ☐ Ringing in Ears
- ☐ Ear – Ache/Drainage
- ☐ Sinus/Allergy Problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____

Endocrine, Hematologic, & 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: _____

Skin & 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: _____

Women Only:

Are you pregnant?
- ☐ **Yes – *Due Date*** ____ /____ /____
- ☐ **No**
- ☐ Infertility
- ☐ Painful or Irregular Periods
- ☐ Vaginal Discharge
- ☐ Other: _____

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 _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

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1 – What is your pain RIGHT NOW?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.