

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) _____

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 _____

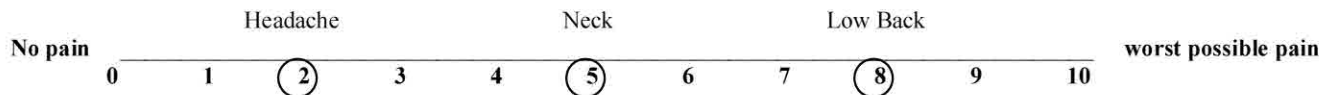
Date _____

Please read carefully:

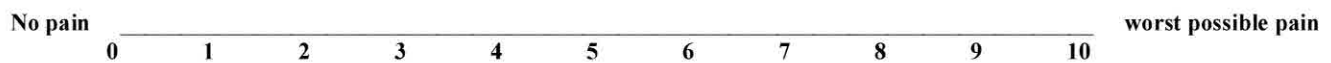
Instructions: Please circle the number that best describes the question being asked.

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.

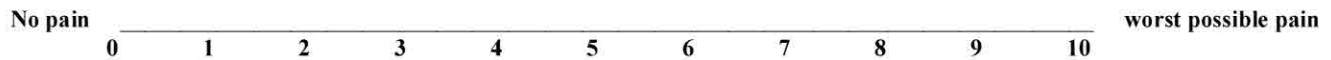
Example:



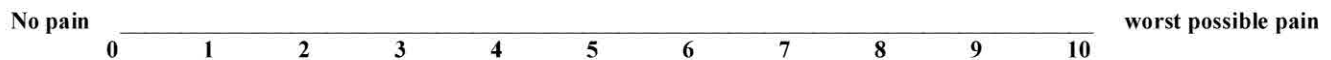
1 – What is your pain RIGHT NOW?



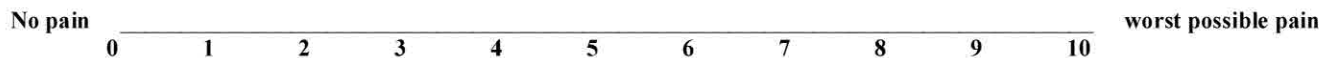
2 – What is your TYPICAL or AVERAGE pain?



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



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



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.

