

# 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 Home Phone 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 Hawaii 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:** \_\_\_\_\_

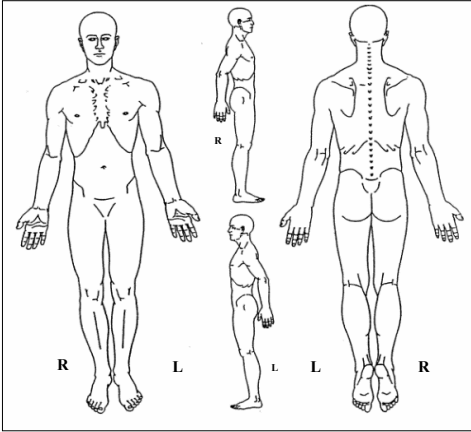
**Secondary Complaints:** \_\_\_\_\_

**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) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



