INTRODUCTION PATIENT CASE HISTORY

Today's Date://								
PATIENT INFORMATION								
Name: (First MI Last)			Preferred Name:					
Address:		Cit	y:	State:	Zip:			
Date of Birth:	Gender:	Male Female	S	ocial Security #:				
Home:	Mobile:	Wo	rk:					
Email:								
Preferred Method of Contact	t: Text	Email	Home Phone	Other:	_			
*Referred By: (Name)								
•	Co-Work	ter Doctor						
Race & Ethnicity: (Choose up to	o 2)	Preferred						
African American or Blac	ek	Englis	h					
American Indian or Alask	an Native	Spanis	sh					
Asian		Other:						
Hispanic or Latino		Declir	ie					
Native Hawaii or Other P	acific Islander							
White								
Decline								
EMERGENCY CONTACT INFORMATION								
Name: (First MI Last)			Primary Ca	Primary Care Physician:				
Home:		Doctor's Pl	Doctor's Phone:					
Relationship:								
Child Parent Spe		er:	_					
INANCIAL INFORMATION								
Is today's visit the result of an	accident?		Where wou	ld you like statement	s sent?			
No Auto Wo	ork Ot	her:	Self	Other (Details below	²)			
Will we be working with insur	ance? No	Yes (Details)	Name:					
Primary:	ID#	·						
Secondary:			Phone:	Email:				

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

HISTORY OF PRESENT ILLNESS

Major Complaint:		Secondary Complaints:			
When did it start?/ Wha					
Which daily activities are being affected by					
	Major Co				
Location of Symptoms and Radiation	Quality:		Previous Treatment:		
	Sharp		None		
	Stabbing		Chiropractor		
	Burning		Medical Doctor		
	Achy		Physical Therapy		
	Dull		ER/Urgent Care		
	Stiff & Sore		Orthopedic		
	Other:		Other:		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Does it radiate?		Previous Diagnostic Testing:		
R L L R		indicate on drawing)	None		
	Improves with:		X-rays		
P Pain	Ice		MRI		
S _ Spasm	Heat		CT		
Grade Intensity/Severity:	Movement		Other:		
None (0/10)	Stretching		*Women: Are you pregnant?		
Mild (1-2/10)	OTC Medications:		No Last Menstrual Period://_		
Mild-Moderate (2-4/10)	Other:		Yes Due date://		
Moderate (4-6/10)	Worsens with:		Present Illness Comments:		
Moderate-Severe (6-8/10)	Sitting				
Severe (8-10/10)	Standing/Walking				
Frequency:	Lying Down/Sleep	ing			
Off & On	Overuse/Lifting				
Constant	Other:				
Prescription Medications & Supplements:	None	Allergies to Med	lications: No known drug allergies		
Yes (List – Name, dosage, frequency)		Yes (List - Name	and reaction)		

PAST, FAMILY, AND SOCIAL HISTORY

Illnesses: Hospitalizations: (ns: (N	on-sure	ical wii	th Da	ate) Medical History Comments:	
Asthma										•
Autoimmune Disorder (7)	тре)									
Blood Clots										
Cancer (Type) Surger										
CVA/TIA (stroke)					ncer					
Diabetes Orthopedic Migraine Headaches Shoulder –						D / I				
Osteoporosis							R/L R/I			
Other:				Elbow/Forearm – R / L Wrist/Hand – R / L						
						Hip –	R/L			<u> </u>
					K	nee –	R/L			
					Ankle/F	oot –	R/L			
Injuries:					inal Sur					
Back Injury Broken Bones					Neck: _					
Head Injury]	Back: _					
Neck Injury				Ot	ner:					
Falls										
Other:										
AMILY HISTORY (Please mark X to										
			na use co	mmenis	io eiabor	aie.)				
Unknown Unrem	arkabie	e							Ì	Family History Comments:
	er	e	g1	g2	g3	11	12	3		, ,
	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3	-	
	Σ	Ϋ́	Sik	Sik	Sik	ū	ū	כו	-	
Gender	F	M							-	
Age at death (if Deceased)									_	
Aneurysms									-	
CVA (Stroke)									-	
Cancer									-	
Diabetes									-	
Heart Disease									-	
Hypertension									-	
Other Family History									_	
	RY									
OCIAL AND OCCUPATIONAL HISTOR	Marri	ed	Divorc	ed	Other		Caf	feine 1	Use:	:
OCIAL AND OCCUPATIONAL HISTOI Marital Status: Single	Mairie		Other:					Cof	fee	Tea Energy Drinks Soda Never
Marital Status: Single		4								Tea Energy Ethnis South Trevel
Marital Status: Single Children: None 1 2	3			No	Stude	a+	Eva	naica t	funa	I H O M O V A
Marital Status: Single Children: None 1 2 Student Status: Full Student	3 lent	Part S	Student				Exe		-	quency:
Marital Status: Single Children: None 1 2	3 lent	Part S	Student		n-Studer ge Grad		Exe	r cise 1 Dai	-	quency: 3-4xs/week 2-3xs/week Rarely 1
Marital Status: Single Children: None 1 2 Student Status: Full Student	3 lent Hi	Part S gh Sc	Student hool	Colle	ge Grad			Dai	ly	3-4xs/week 2-3xs/week Rarely
Marital Status: Single Children: None 1 2 Student Status: Full Student Status: Full Student Status: Post Grad. Other:	3 lent Hi	Part S gh Sc	Student	Colle	ge Grad			Dai	ly	•
Marital Status: Single Children: None 1 2 Student Status: Full	3 lent Hi	Part S gh Sc ion)	Student	Colle	ge Grad			Dai	ly	3-4xs/week 2-3xs/week Rarely
Marital Status: Single Children: None 1 2 Student Status: Full Student S	3 lent Hi	Part S gh Sc ion) eft	Student hool Amb	Colle	ge Grad	· 		Dai	ly	3-4xs/week 2-3xs/week Rarely
Marital Status: Single Children: None 1 2 Student Status: Full Status:	3 lent Hi Coccupation Let	Part S gh Sc ion) eft noker,	Student hool Amb	Collegoidextro	ge Grad	· 		Dai	ly	3-4xs/week 2-3xs/week Rarely
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Account No: _

Today's Date: _____ Patient Name:

REVIEW OF SYSTEMS

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Many of the following conditions respond to chiropractic treatment.

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

Constitutional: (General)	Respiratory:	Review of Systems Comments:
Fever	Difficulty Breathing	
Fatigue	Cough	
Other:	Other:	
None in this Category	None in this Category	
Musculoskeletal:	Eyes & Vision:	
Joint Pain/Stiffness/Swelling	Eye Pain	,
Muscle Pain/Stiffness/Spasms	Blurred or Double Vision	
Broken Bones	Sensitivity to Light	
Other:	Other:	
None in this Category	None in this Category	
Neurological:	Head, Ears, Nose, & Mouth/Throat:	
Dizziness or Lightheaded	Frequent or Recurrent Headaches	
Convulsions or Seizures	Ear - Ache/Ringing/Drainage	
Tremors	Hearing Loss	
Other:	Sensitivity to Loud Noises	
None in this Category	Sinus Problems	
Psychiatric: (Mind/Stress)	Sore Throat	
Nervousness/Anxiety	Other:	
Depression	None in this Category	
Sleep Problems	Endocrine:	
Memory Loss or Confusion	Infertility	
Other:	Recent Weight Change	
None in this Category	Eating Disorder	
· .	Other:	
Genitourinary: Frequent or Painful Urination	None in this Category	
Blood in Urine	Hematologic & Lymphatic:	
Incontinence or Bed Wetting	Excessive Thirst or Urination	
Painful or Irregular Periods	Cold Extremities	
Other:	Swollen Glands	
None in this Category	Other:	
Gastrointestinal:	None in this Category	
Loss of Appetite	Integumentary: (Skin, Nails, & Breasts)	
Blood in Stool or Black Stool	Rash or Itching	
Nausea or Vomiting	Change in Skin, Hair, or Nails	
Abdominal Pain	Non-healing Sores or Lesions	
Frequent Diarrhea	Change of Appearance of a Mole	
Constipation	Breast Pain, Lump, or Discharge	
Other:	Other:	
None in this Category	None in this Category	
Cardiovascular & Heart:	Allergic/Immunologic:	
Chest Pains/Tightness	Food Allergies	
Rapid or Heartbeat Changes	Environmental Allergies	
Swelling of Hands, Ankles, or Feet	Other:	
	None in this Category	
Other:	3 7	
•	my knowledge and certify them to be true and correc	
Patient or Guardian Signature		Date

