Today's Date: _____

GILMORE CHIROPRACTIC Introduction Patient Case History

Patient Information

Name (First, MI, Last) | Preferred Name

Address | City | State/Zip

Home Phone | Mobile Phone | Work Phone | Gender ○ M ○ F

Email | Date of Birth | Marital Status ○ Married ○ Single ○ Other

Occupation | Employer

Referred by (name) ○ Family ○ Friend ○ Co-worker ○ Doctor ○ Other

CMS required providers to report both race and ethnicity

Ethnicity ○ Not Hispanic or Latino ○ Hispanic or Latino ○ Other ○ Decline to answer | Preferred Language

Race ○ Asian ○ Black/African American ○ American Indian or Alaskan Native ○ White (Caucasian) ○ Hawaiian or Pacific Islander ○ Other ○ Decline

Smoking Status ○ Every Day ○ Some Days ○ Former ○ Never

Emergency Contact Information

Full Name | Preferred Contact Number

Relationship ○ Child ○ Parent ○ Spouse ○ Other

Primary Care Physician | Physician's Phone

Financial Information - *PLEASE ALLOW US TO PHOTOCOPY YOUR INSURANCE CARD.*

○ Self Pay (Cash) ○ Insurance ○ Personal Injury/Auto ○ Other (Please explain)

Primary Insurance | Secondary Insurance

Policy Holder | Policy Holder

Relation to Insured ○ Self ○ Spouse ○ Parent ○ Child ○ Other | Relation to Insured ○ Self ○ Spouse ○ Parent ○ Child ○ Other

Patient Name | Patient Name

It is usual and customary to pay for services as rendered unless otherwise arranged.

Patient No: _____

Patient Name: _____

Current Condition Information- *PLEASE ANSWER ALL QUESTIONS.*

Major complaint

When Did This Episode Start (date) | **What Event Caused it?**

If this is NOT the first time, how long has this been a recurring problem?

Intensity

◯ None (0) ◯ Mild (1-2) ◯ Mild-Moderate (2-4) ◯ Moderate (4-6) ◯ Moderate-Severe (6-8) ◯ Severe (8-10)

Is the Complaint

◯ Sharp ◯ Stabbing ◯ Burning ◯ Achy ◯ Dull ◯ Stiff and Sore ◯ Tingling ◯ Other

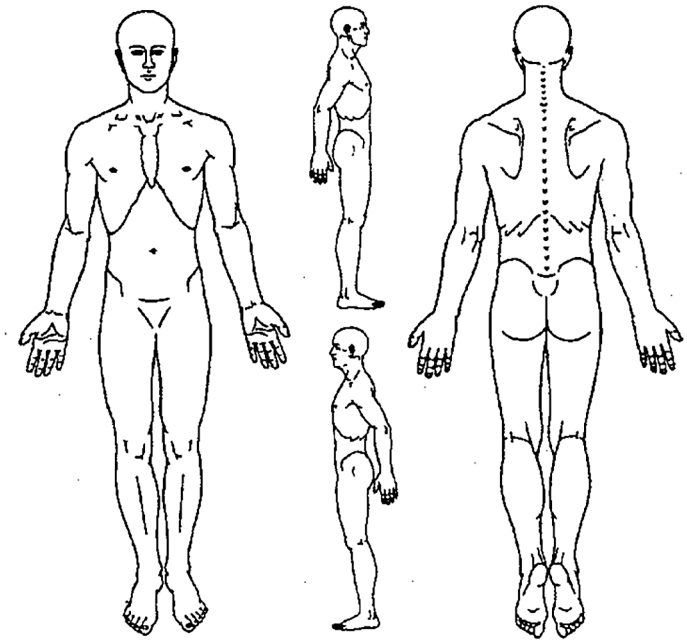
The complaint is

◯ Constant ◯ On/Off

Does it Radiate/Shoot to any Areas of Your Body? ◯ Yes ◯ No

If yes, where?

Draw Areas of Complaints



What Makes it Better?

◯ Ice ◯ Heat ◯ Rest ◯ Movement ◯ Stretching ◯ OTC Meds ◯ Rx Meds ◯ Chiropractic

What Makes it Worse?

◯ Sit ◯ Stand ◯ Walk ◯ Lying ◯ Sleep ◯ Movement

Who else Have You Seen for This?

◯ No one ◯ DC ◯ MD ◯ PT ◯ Massage ◯ ER ◯ Other

Where?

Diagnostic Tests | **Where?**

◯ None ◯ X-rays ◯ MRI ◯ CT ◯ Other

What Daily Activities are Being affected?

Family Health History

Does anyone in your IMMEDIATE family have a history of

◯ Heart Disease (Who?)

◯ Cancer (Who?)

◯ Stroke (Who?)

(Type?)

Other relevant family history:

Patient Name: _____

Past Health History

Injuries, Traumas, or Hospitalizations:

Surgeries (Date, Type, Reason)

Current Medications (Did you bring a list? May we have a copy? If not, please list here)

Allergies to Medications (List and reactions)

Vitamins Ilist all and frequency)

Are your CURRENTLY experiencing any of these symptoms? (Check all that apply)

General
- ◯ Recent Intentional Weight Change
- ◯ Fever
- ◯ *None in this category*

Musculoskeletal
- ◯ Low Back Pain
- ◯ Mid Back Pain
- ◯ Neck Pain
- ◯ Arm Problems
- ◯ Leg Problems
- ◯ Broken Bones
- ◯ Muscle Spasms/Cramps
- ◯ *None in this category*

Neurological
- ◯ Numbness or Tingling Sensations
- ◯ Loss of Feeling
- ◯ Dizziness or Light Headed
- ◯ Frequent or Recurrent Headaches
- ◯ Convulsions or Seizures
- ◯ Have you ever had a head injury?
- ◯ Had an auto accident? Year: _____
- ◯ *None in this category*

Gastrointestinal
- ◯ Loss of Appetite
- ◯ Blood in Stool
- ◯ Change in Bowel Movements
- ◯ Nausea or Vomiting
- ◯ Abdominal Pain
- ◯ Constipation
- ◯ *None in this category*

Cardiovascular & Heart
- ◯ Chest Pains
- ◯ Rapid or Heartbeat Changes
- ◯ Blood Pressure Problems
- ◯ Swelling of Hands, Ankles, or Feet
- ◯ Heart Problems
- ◯ *None in this category*

Respiratory
- ◯ Difficulty Breathing
- ◯ Persistent Pain
- ◯ Coughing Blood
- ◯ Asthma or Wheezing
- ◯ Tobacco Use
- ◯ *None in this category*

Eyes and Vision
- ◯ Wear Contacts/Glasses
- ◯ Blurred or Double Vision
- ◯ Eye Disease or Injury
- ◯ *None in this category*

Ears, Nose and Throat
- ◯ Swollen Glands in Neck
- ◯ Ringing in the Ears
- ◯ Ear-Ache/Ringing/Drainage
- ◯ Sinus/Allergy Problems
- ◯ *None in this category*

Mind/Stress
- ◯ Nervousness
- ◯ Depression
- ◯ Sleep Problems
- ◯ Memory Loss or Confusion
- ◯ *None in this category*

Endocrine, Hematologic, and Lymphatic
- ◯ Thyroid Problems
- ◯ Diabetes
- ◯ Cold Extremities
- ◯ Heat or Cold Intolerance
- ◯ Immune System Disorder
- ◯ *None in this category*

Skin and Breasts
- ◯ Rash or Itching
- ◯ Non-healing Sores
- ◯ Breast Pain
- ◯ Breast Lump
- ◯ Breast Discharge
- ◯ *None in this category*

Genitourinary
- ◯ Kidney Stones
- ◯ Burning/Painful Urination
- ◯ Change in Force/Strain w/Urination
- ◯ Frequent Urination
- ◯ Urination Leakage or Bed Wetting
- ◯ Blood in Urine
- ◯ *None in this category*

Are you Pregnant?
- ◯ Yes– Due Date _____
- ◯ No–Last menstrual Period_____
- ◯ Painful or Irregular Periods
- ◯ Urine Leakage with Coughing/Sneezing
- ◯ Urine Leakage with Laughing/Lifting
- ◯ *None in this category*

Pregnancies Outcome & Date

_____

_____

Other Conditions Not Listed: _____

Is there anything else you would like the doctor to know? _____

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. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature **Date**

Doctor Signature **Date**

Name (First, Middle, Last) : _____ Today's Date: _____

Auto Accident Questionnaire

Please use the back of this page if needed

Accident Information

Date and Time of Accident

Number of People in the Vehicle

Were you the

○ Driver ○ Front passenger ○ Rear passenger ○ Behind driver ○ Middle ○ Behind passenger

Name of Driver *if not you*

Were you wearing seatbelt?

○ Yes ○ No

Make/Model of the Vehicle

Did airbags inflate?

○ Yes ○ No

Where was vehicle impacted?

○ Front ○ Rear ○ Driver Side ○ Passenger side

In relation to the base of your skull, where was headrest?

○ Above ○ Below ○ At Base

During impact were you facing

○ Forward ○ Backward ○ Right ○ Left

Did any part of your body strike anything in the vehicle?

○ Yes ○ No

Please describe

Were you rendered unconscious?

○ Yes ○ No

If yes, for how long?

What was approximate speed of your vehicle?

Speed of other vehicle?

In own words, please describe the accident in detail:

Legal Information

Was a police report filed?

○ Yes ○ No

Have you retained an attorney?

○ Yes ○ No

If yes, name of attorney

Attorney Phone

Auto Insurance Company

Claim #

Other Auto Insurance Company

Claim #

Medical Information (At time of the accident)

Did you feel pain immediately after accident?

○ Yes ○ No

If no, when?

○ Later that day ○ Next Day ○ When?

Did you go to hospital or see other doctor?

○ Yes ○ No

If yes, when did you go?

○ Immediately ○ Next Day ○ Other

Name of hospital and/or doctor

Were any x-rays taken?

○ Yes ○ No

Medical Information (Since the accident)

Are your symptoms?

○ Getting Better ○ Same ○ Worse

Have you been to work since this injury?

○ Yes ○ No

Are your work activities restricted as a result of the injury?

○ Yes ○ No

Patient or Guardian Signature

Date

Patient No: _____