

Introduction Patient Case History

Patient Information

Name (First, MI, Last)		Preferred Name	
Address		City	State/Zip
Home Phone	Mobile Phone	Work Phone	Gender <input type="radio"/> M <input type="radio"/> F
Email	Date of Birth	Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Other	
Occupation	Employer		
Referred by (name)		<input type="radio"/> Family <input type="radio"/> Friend <input type="radio"/> Co-worker <input type="radio"/> Doctor <input type="radio"/> Other	

CMS required providers to report both race and ethnicity

Ethnicity	Preferred Language
<input type="radio"/> Not Hispanic or Latino <input type="radio"/> Hispanic or Latino <input type="radio"/> Other <input type="radio"/> Decline to answer	
Race	
<input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> American Indian or Alaskan Native <input type="radio"/> White (Caucasian) <input type="radio"/> Hawaiian or Pacific Islander <input type="radio"/> Other <input type="radio"/> Decline	
Smoking Status	
<input type="radio"/> Every Day <input type="radio"/> Some Days <input type="radio"/> Former <input type="radio"/> Never	

Emergency Contact Information

Full Name	Preferred Contact Number
Relationship <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Spouse <input type="radio"/> Other	
Primary Care Physician	Physician's Phone

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

<input type="radio"/> Self Pay (Cash) <input type="radio"/> Insurance <input type="radio"/> Personal Injury/Auto <input type="radio"/> Other (Please explain)	
Primary Insurance	Secondary Insurance
Policy Holder	Policy Holder
Relation to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Child <input type="radio"/> Other	Relation to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Child <input type="radio"/> Other
Patient Name	Patient Name

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

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

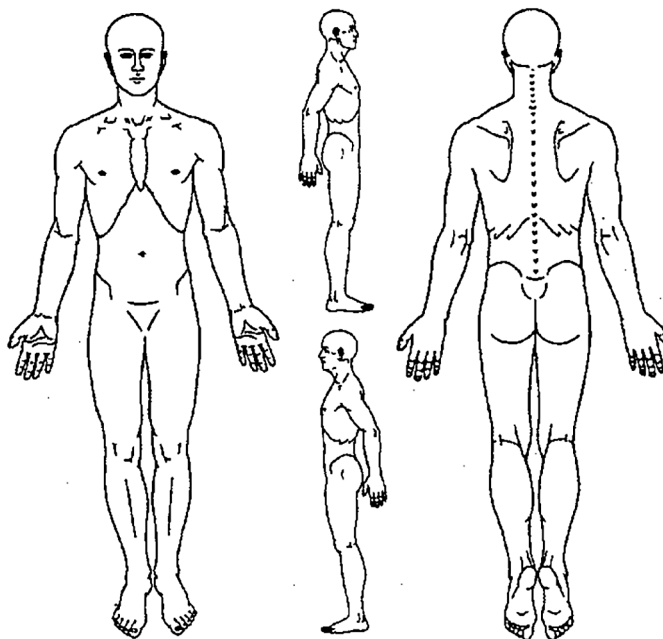
- Constant On/Off

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

- None X-rays MRI CT Other

Where?

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 No: _____

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

Vitamins

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

Patient No: _____