

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Mobile Carrier: \_\_\_\_\_ Work: \_\_\_\_\_  
Email: \_\_\_\_\_ Gender: M / F Marital Status: Single / Married / Other  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Student Status: Full Student / Part Student / Non-Student Employed: Y / N  
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline Preferred Language: English / Decline / Other: \_\_\_\_\_  
Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline  
\*Referred By: (Name): \_\_\_\_\_ Family / Friend / Co-Worker / Doctor / Other Source

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_  
Relationship: Child / Parent / Spouse / Other: \_\_\_\_\_

## FINANCIAL INFORMATION

Insurance  Worker's Comp  Self-Pay (Cash)  Personal Injury/Auto  Other (please explain): \_\_\_\_\_

### PRIMARY INSURANCE

Insurance Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - (Relationship) \_\_\_\_\_

Other than Self:

Name: (First MI Last) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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

Patient No: \_\_\_\_\_

# PATIENT CASE HISTORY

**HISTORY OF CURRENT CONDITION**

**Describe Major Complaint:** \_\_\_\_\_

**Describe any Secondary Complaints:** \_\_\_\_\_

**Describe WHEN and HOW this began:** \_\_\_\_\_

**Grade Intensity/Severity of Complaint:** None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

**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 diagnostic testing?** X-rays / MRI / CT / Other: \_\_\_\_\_ **When and Where?** \_\_\_\_\_

HEALTH HISTORY - (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

**Medications and Supplements:**

**Allergies to Medications:** NONE

Name	Reaction

**Current Medications & Supplements:** NONE

Name	Dosage	Frequency	Method

**Past Health History:** (Please list any past...)

**Number of Falls in the last 24 months:** \_\_\_\_\_ **Injuries?** Y or N

**Surgeries:** NONE

Date	Area of the Body	Reason

**Major Injuries / Traumas / Hospitalizations:** NONE

Date	Describe

**Family Health History:**

N/A

**List relevant major health problems of First degree relatives:**

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

**Social and Occupational History:**

**Smoking/Tobacco Use:** Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

**Education:** High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

**Patient No:** \_\_\_\_\_

**Are you currently experiencing any of these symptoms? (Check all the apply)**  
**Many of the following conditions respond to Chiropractic and Acupuncture treatment.**

**General: (constitutional)**

- Recent Weight Change
- Fever
- Fatigue
- None in this Category

**Musculoskeletal:**

- Low Back Pain
- Mid Back Pain
- Neck Pain
- Arm Problems \_\_\_\_\_
- Leg Problems \_\_\_\_\_
- Painful Joints
- Stiff/Swollen Joints
- Sore/Weak Muscles or Joints
- Muscle Spasms/Cramps
- Broken Bones \_\_\_\_\_
- Other: \_\_\_\_\_
- None in this Category

**Neurological:**

- Numbness or tingling sensations
- Loss of Feeling
- Dizziness or light headed
- Frequent or Recurrent Headaches
- Convulsions or seizures
- Tremors
- Stroke
- Other: \_\_\_\_\_
- None in this Category

**Mind/Stress:**

- Nervousness
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: \_\_\_\_\_
- None in this Category

**Genitourinary:**

- Sexual Difficulty
- Kidney Stones
- Burning/Painful Urination
- Change in force/strain w Urination
- Frequent Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Other: \_\_\_\_\_
- None in this Category

**Gastrointestinal:**

- Loss of Appetite
- Blood in Stool
- Change in Bowel Movements
- Painful Bowel Movements
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: \_\_\_\_\_
- None in this Category

**Cardiovascular & Heart:**

- Chest Pains
- Rapid or Heartbeat changes
- Blood Pressure Problems
- Swelling of Hands, Ankles, or Feet
- Heart Problems
- Other: \_\_\_\_\_
- None in this Category

**Respiratory:**

- Difficulty Breathing
- Persistent Cough
- Coughing Blood
- Asthma or Wheezing
- Lung Problems
- Other: \_\_\_\_\_
- None in this Category

**Eyes and Vision:**

- Wear contacts/glasses
- Blurred or double vision
- Glaucoma
- Eye disease or injury
- Other: \_\_\_\_\_
- None in this Category

**Ears, Nose and Throat:**

- Bleeding gums / mouth sores
- Bad Breath or bad taste
- Dental Problems
- Swollen throat or voice change
- Swollen glands in neck
- Ringing in the ears
- Ear - Ache/Ringing/Drainage
- Sinus / Allergy problems
- Nose Bleeds
- Hearing Loss
- Other: \_\_\_\_\_
- None in this Category

**Endocrine, Hematologic, and**

**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: \_\_\_\_\_
- None in this Category

**Skin and 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: \_\_\_\_\_
- None in this Category

**Women Only:**

**Are you pregnant?**

- Yes - Due Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- No - Last Menstrual Period  
\_\_\_\_/\_\_\_\_/\_\_\_\_

- Infertility
- Painful or Irregular periods
- Vaginal Discharge
- Other: \_\_\_\_\_
- None in this Category

**Pregnancies:**

Date	Outcome

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 \_\_\_\_\_

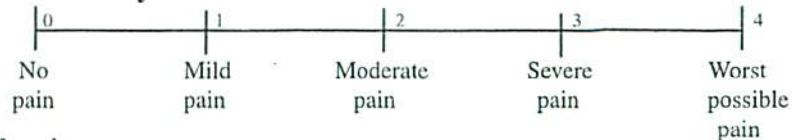
Patient No: \_\_\_\_\_

# Functional Rating Index

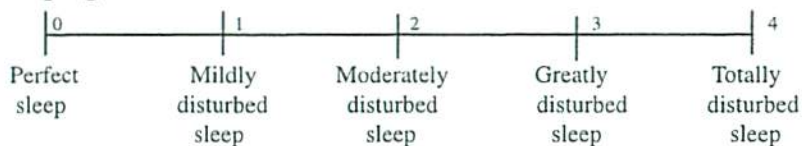
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

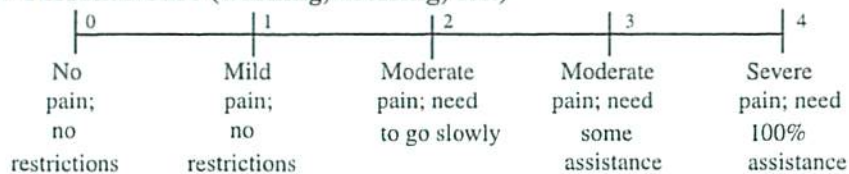
## 1. Pain Intensity



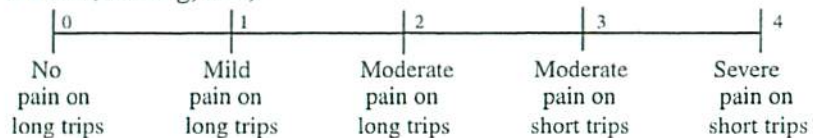
## 2. Sleeping



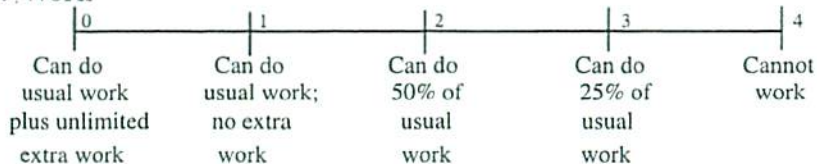
## 3. Personal Care (washing, dressing, etc.)



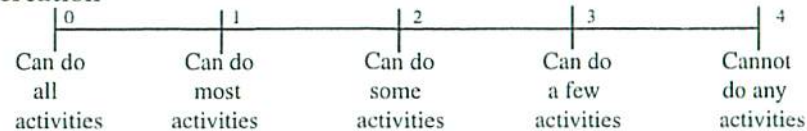
## 4. Travel (driving, etc.)



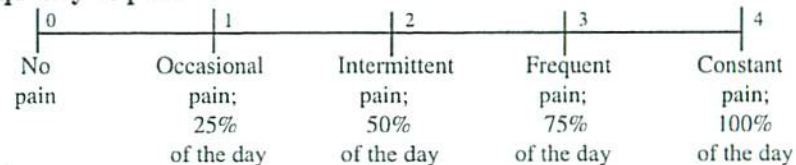
## 5. Work



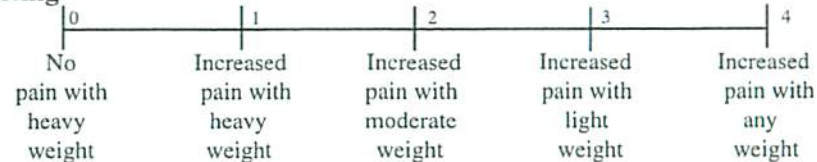
## 6. Recreation



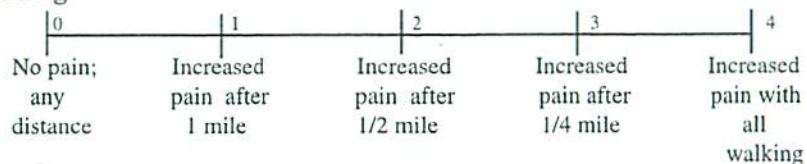
## 7. Frequency of pain



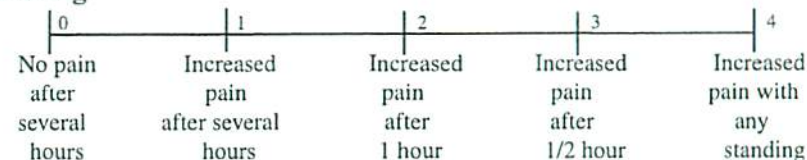
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_  
PRINTED

\_\_\_\_\_  
 Signature

Total Score \_\_\_\_\_

\_\_\_\_\_  
 Date