INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____________

PATIENT INFORMATION

Name: (Last, First MI)______________________________ **Preferred Name:** ____________

Address: ______________________ **City:** ______________ **State:** _____ **Zip:** ________

Home: ____________ **Mobile:** ____________ **Mobile Carrier:** ______________ **Work:** ____________

Email: ______________________ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #:______________________ **Date of Birth:** ______________________

Student Status: Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** ______________

***Referred By:** ______________________

Ethnicity: Hispanic or Latino / Other

Preferred Language: ______________________

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ______________________ **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

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

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:** ________

Who is responsible for payment? Self / Other - *(Relationship)* ______________

Other than Self:
Full Name: ______________________ **Phone:** ______________

Address: ______________________ **City:** ______________ **State:** _____ **Zip:** ________

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

Patient No: ________

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PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ______________________________

Began When? ___/____/_____ **Describe how this began:** ______________________________

____

____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

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)* ______________

<u>*Head*</u> - Base of Skull / Forehead / Sides-Temple R / L / Both <u>*Leg*</u> - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

<u>*Arm*</u> – Across Shoulder / Elbow / Hand-Fingers R / L / Both <u>*Other Area:*</u> ______________

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)* ______________

<u>For this CURRENT condition, have you:</u>

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: __________ **Where?** __________
- **Had any previous Surgery or Interventions in this area?** *(Describe)* ______________
- **Taken any Medications?** OTC / Prescriptions ______________
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: __________ **When and Where?** __________

Describe any Secondary Complaints: ______________________________

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

<u>Medications:</u>

Allergies to Medications: *NONE* *(List)* ______________

____

Current Medications: *NONE*

(Already have a list? We can make a copy.) ______________

____

____

____

____

<u>Past Health History:</u> *(Please list any past...)*

Surgeries – Date, Type, and Reason: *NONE*

____

____

____

____

Major Injuries/Traumas: *NONE* ______________

____

____

____

Major Hospitalizations: *NONE* ______________

____

____

<u>Family Health History:</u> *(Please mark N/A if not relevant.)*

List *relevant* major health problems of immediate relatives:

____

____

____

Deaths in immediate family: *(Cause and at what Age?)*

____

____

____

<u>Social and Occupational History:</u>

Level of Education Completed: ______________

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

____

____

____

____

Habits:

Cigarettes – *(#/day)* ______________

Alcohol – *(amount/day)* ______________

Coffee/Tea – *(cups/day)* ______________

Rec. Drugs *(List)* ______________

Patient No: __________

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PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI)________________________ **Today's Date:** __________

PEDIATRIC REVIEW OF SYSTEMS

Pediatric:
- ☐ ADHD
- ☐ Allergies/Asthma
- ☐ Autism
- ☐ Back/Neck Pain
- ☐ Bed Wetting
- ☐ Behavioral issues
- ☐ Chronic Earaches
- ☐ Colic
- ☐ Constipation
- ☐ Growing Pains
- ☐ Nightmares
- ☐ Reflux
- ☐ *None in this Category*

Childhood Diseases:
- ☐ Chicken Pox: Age ____
- ☐ Measles: Age ____
- ☐ Meningitis: Age ____
- ☐ Mumps: Age ____
- ☐ Rubella: Age ____
- ☐ Tuberculosis: Age ____
- ☐ Whooping Cough: Age ____
- ☐ Other:__________ Age ____
- ☐ *None in this Category*

Has your child been vaccinated?
☐ **No** ☐ **Yes**
*(Any Adverse Reactions? – Describe:)*____________
____

INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Birth Weight: ________ **Birth Length:** ________ **Full Term?** ☐ **No** ☐ **Yes** *(Describe)*____________________

Complications during pregnancy? ☐ **No** ☐ **Yes** *(Describe)*____________________

Medications during pregnancy or delivery? ☐ **No** ☐ **Yes** *(List)* ____________________

Cigarette / Alcohol / Drugs during pregnancy? ☐ **No** ☐ **Yes** *(List)* ____________________

Birth Interventions? ☐ **No** ☐ **Yes** ☐ Forceps ☐ Vacuum ☐ Caesarian ☐ Other: ____________

Complications during delivery? ☐ **No** ☐ **Yes** *(Describe)* ____________________

Feeding History:

Breast fed? ☐ **No** ☐ **Yes** *(How Long?)*_____ **Formula fed?** ☐ **No** ☐ **Yes** *(How Long?)*_____ *(Type?)*____________

Introduced to cereal at ____ months old. **Solids at____ months old.** **Cow's milk at____ months old.**

Food / Juice allergies or intolerances? ☐ **No** ☐ **Yes** *(Describe)*____________________

Developmental History:

Sleep *(Hours per Night?)* ______ **Problems Sleeping?** *(Describe)*____________________

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: ________________________ ***(Doctor's Name)*** and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: ________________________ ***(Minor Patient's Name)***

____
Printed Name of Parent or Guardian

______________________________ ________ ______________________________ ________
Signature of Parent or Guardian Date Witness Date

Patient No: __________

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