

Confidential Patient Case History

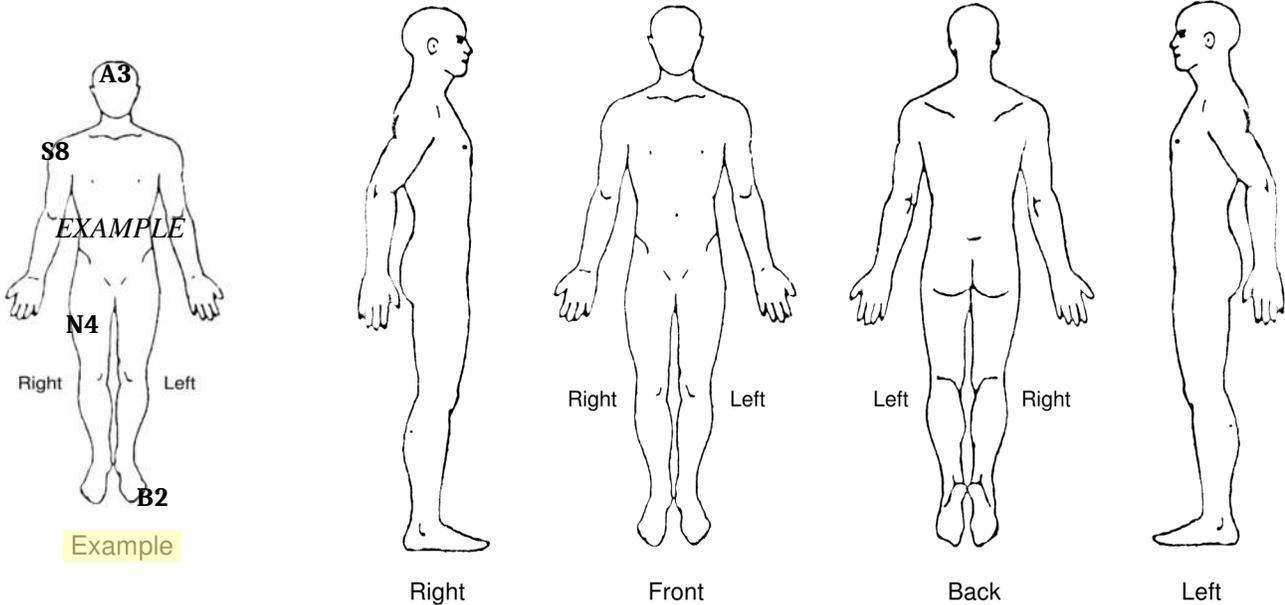
Name: _____ Today's Date: _____ Mobile Phone: _____
 Preferred Name: _____ Email: _____ Work Phone: _____
 Date of Birth: _____ Age: _____ Gender: _____ Home Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Marital Status: Single Married Divorced Partnered Widowed No. Of Children: _____
 Occupation: _____ Referred By: _____

Complaints

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Description Numbness Pins & Needles Burning Aching Stabbing
 Symbol NNNN PPPP BBBB AAAA SSSS

DESCRIBE ANY AREAS OF PAIN
 NOT OTHERWISE INDICATED:



2. Additional Complaints?

Yes No

Please list: _____

8. If your complaints include pain, is it relieved by?

Nothing Heat Sitting
 Rest Stretching Standing
 Ice Exercise
 Other _____

3. How and when did your symptoms begin?

Date _____ Cause _____

9. Have you had recent treatments for this condition?

Yes No (If Yes, list dates, treatments, and doctors)

4. How often do your symptoms occur?

Occasional Intermittent
 Frequent Constant
 Other _____

10. Has this condition existed in the past?

Yes No

5. How would you rate your pain today with

0 being no pain and 10 being the worst pain?

11. Since your symptoms began, have you noticed a change in?

If Yes, indicate

Onset date

Duration

Bowel Function		
Bladder Function		
Sexual Function		

6. Are you getting?

Better Worse Same

7. If your complaints include pain, is it aggravated by?

Coughing Reaching Standing
 Sneezing Lifting Walking
 Bending Sitting Neck Movement
 Straining at Stool Other _____

KLEIN SPINE

DANIEL KLEIN, D.C.
 100 QUAKER LANE
 VILLANOVA, PA 19085



PHONE: 610-525-2209
 FAX: 610-525-1503

Review of Systems

1. Are you presently suffering (or within the past six months suffered) from any of the following?

a. General

- Normal
- Weakness
- Night Sweats
- Other _____
- Fatigue
- Weight Change
- Loss of Sleep
- Chills
- Fever

b. Skin

- Normal
- Hair Changes
- Itching
- Eczema
- Redness
- Bruise Easily
- Rash
- Nail Changes
- Dryness

c. Neurologic

- Normal
- Nervousness
- Other _____
- Convulsions
- Dimness
- Headache
- Fainting

d. Eyes

- | | Left | Right |
|---|--------------------------------|--------------------------------|
| <input type="checkbox"/> Normal | | |
| <input type="checkbox"/> Vision Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

e. Ears

- | | Left | Right |
|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Normal | | |
| <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ringing | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

f. Nose

- Normal
- Pain
- Other _____
- Infections
- Bleeding
- Absence of Smell
- Sinus Problems

g. Mouth / Throat

- Normal
- Bleeding
- Enlarged Glands
- Other _____
- Sores
- Abnormal Taste
- Absence of Taste
- Tonsillitis

h. Cardio – Vascular – Pulmonary (Heart / Lungs)

- Normal
- Murmur
- Palpitations
- Swollen Extremities
- Other _____
- Varicosities
- Wheezing
- Blue Extremities
- Cough
- Chest Pain
- Difficulty Breathing

i. Breasts

- Normal
- Discharge
- Other _____
- Dimpling
- Pain
- Lumps in Breast(s)
- Redness / Itching

j. Gastrointestinal (Stomach / Digestion)

- Normal
- Vomiting
- Abdominal Pain
- Other _____
- Excess Gas
- Diarrhea
- Constipation
- Decreased Appetite
- Increased Appetite
- Hemorrhoids

k. Genitourinary

- Normal
- Impotence
- Bedwetting
- Abnormal Vaginal Bleeding
- Other _____
- Painful Urination
- Sterility
- Frequent Urination
- Painful Menstruation
- Irregular Menstruation
- Inability to Hold Urine
- Prostate Problems

l. Endocrine (Metabolism)

- Normal
- Tremor
- Other _____
- Goiter
- Sugar In Urine
- Heat / Cold Intolerance

m. Psychology

- Normal
- Mood Swings
- Memory Loss or Impairment
- Other _____
- Phobias
- Depression
- Anxiety

2. What hobbies do you participate in?

- | List Hobbies | Occasionally | Frequently | Constantly |
|--------------|--------------|------------|------------|
| _____ | | | |
| _____ | | | |
| _____ | | | |

What are your habits?

- | | | | |
|------------------------|---|--------------------------|--|
| Smoking | Never <input type="checkbox"/> | Packs / Day _____ | Sleeping Position:
Back
Side
Stomach |
| Alcohol | Never <input type="checkbox"/> | Drinks / Day _____ | |
| Caffeinated Drinks | Never <input type="checkbox"/> | Cups-Glasses / Day _____ | |
| Exercise | Never <input type="checkbox"/> | Days / week _____ | |
| Drug / Substance Abuse | Never <input type="checkbox"/> Yes <input type="checkbox"/> | _____ | |
- If Yes, discuss with doctor
Family History: major condition(s) and/or contributory to your condition

Stated Weight _____ Stated Height _____ Blood Pressure _____

Occupational & Daily Living Information

Medical History

- Job type
 - Full time
 - Part time
 - Temporary
 - Other _____
- Workweek
 - Hours per day _____
 - Days per week _____
 - Other _____
- Do your present complaints affect the number of hours you work per day? Yes No
- Length of time at present occupation _____ years, _____ months
- Job involves
 - Lifting _____ lbs
 - Never
 - Occasionally
 - Frequently
 - Constantly
 - Additional job requirements
 - Bending
 - Stooping
 - Twisting
 - Turning
 - Carrying
 - Walking
 - Other _____
- What is your primary work position / location?
 - Position
 - Seated
 - Other _____
 - Standing
 - Location
 - Desk
 - Other _____
 - Workbench
 - Counter
 - If seated, what type of chair do you use?
 - Executive
 - Bench
 - Steno
 - Stool
 - Other _____
- Do you wear shoes or boots with high heels?
 - Never
 - Occasionally
 - Seldom
 - Frequently
- Are you right or left-handed?
 - Left
 - Right
- Do work activities aggravate your present complaints?
 - Yes
 - No
- Which of the following best describes your stress level?
 - None
 - Moderate
 - Minimal
 - Great
- How do you rate your physical activity at work?
 - Seated more than 50% of the workday
 - Light manual labor
 - Moderate manual labor
 - Heavy manual labor

- Health Care
 - Have you been to a Chiropractor Yes No
 - Do you have a family physician Yes No
 - Date of last physical exam _____
 - Physician's name and address _____
 - Have you been hospitalized in the last 5 years? Yes No
 - Date & reason for hospitalization _____
 - Have you had surgery in the last 5 years? Yes No
 - Date & reason for surgery _____
 - Have you had a serious accident in the past 5 years? Yes No
 - Auto
 - Work
 - Home
 - Other _____
 - List date & describe injury _____
 - Do you have any drug allergies Yes No
 - List drugs _____
 - Are you currently taking any medication Yes No
 - Please note all medications, dosage and condition being treated*

2. If you now have or you ever had one of the following illnesses, please fill in NOW HAVE or HAVE HAD.

No Previous Conditions / Illnesses

- | | | | |
|----------------------|---|----------------------|---|
| NOW HAVE
HAVE HAD | <input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Allergies
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Thyroid Trouble
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder | NOW HAVE
HAVE HAD | <input type="checkbox"/> STI
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cancer
<input type="checkbox"/> Polio
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Serious Injury
<input type="checkbox"/> Bone Fracture
<input type="checkbox"/> Dislocated Joints
<input type="checkbox"/> Spinal Disc Disease/Degeneration
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Mental/Emotional Difficulty
<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____ |
|----------------------|---|----------------------|---|

Insurance Information

Auto Related: Yes | No
 If yes, please provide the following:
 Your Insurance Company:
 Claim #:
 Medical Adjuster Phone #:

Work Related:
 Yes | No

Health Insurance Information:

Primary Insured _____
 Insurance Company _____
 Policy Number _____
 Group Number _____