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: _____

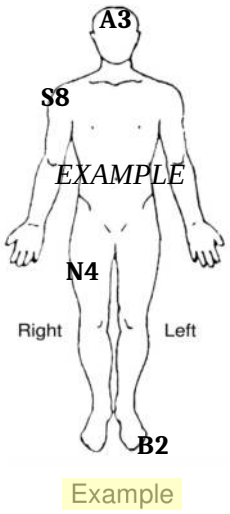
Occupation: _____ Referred By: _____

Complaints

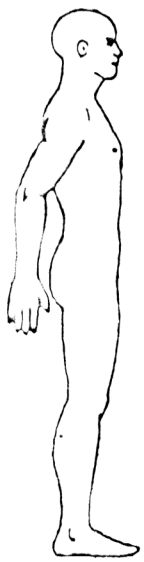
Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

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

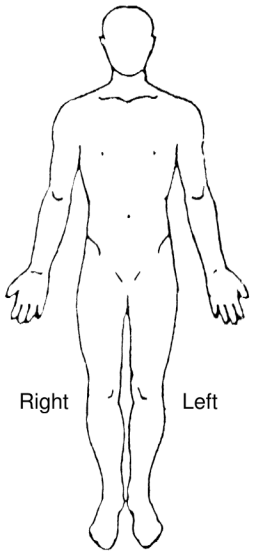
DESCRIBE ANY AREAS OF PAIN NOT OTHERWISE INDICATED: _____



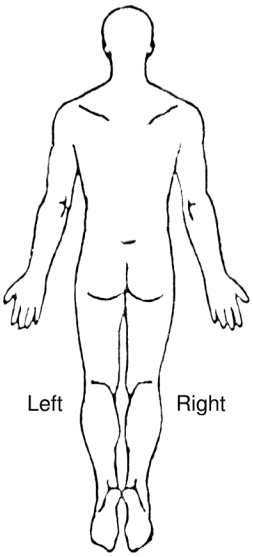
Example



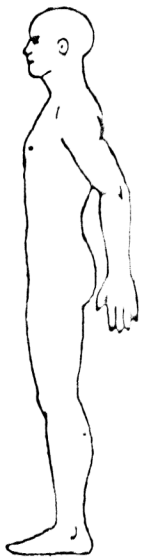
Right



Front



Back



Left

2. Additional Complaints?
☐ Yes ☐ No Please list:

_____

_____

_____

3. How and when did your symptoms begin?
Date: _____ Cause: _____

4. How often do your symptoms occur?
☐ Occasional ☐ Intermittent
☐ Frequent ☐ Constant
☐ Other: _____

5. How would you rate your pain today with 0 being no pain and 10 being the worst pain?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

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: _____

8. If your complaints include pain, is it relieved by?
☐ Nothing ☐ Heat ☐ Sitting
☐ Rest ☐ Stretching ☐ Standing
☐ Ice ☐ Exercise
☐ Other: _____

9. Have you had recent treatments for this condition?
☐ Yes ☐ No (If Yes, list dates, treatments, and doctors)

_____

_____

_____

10. Has this condition existed in the past? ☐ Yes ☐ No

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

If Yes, indicate	Onset date	Duration
Bowel Function		
Bladder Function		
Sexual Function		

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Review of Systems

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

a. General

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

b. Skin

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

c. Neurologic

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

d. Eyes

	Left	***Right***
☐ Normal		
☐ Vision Trouble	☐	☐
☐ Pain	☐	☐
☐ Discharge	☐	☐
☐ Other	☐_____	☐_____

e. Ears

	Left	***Right***
☐ Normal		
☐ Hearing Trouble	☐	☐
☐ Ringing	☐	☐
☐ Pain	☐	☐
☐ Discharge	☐	☐
☐ Other	☐_____	☐_____

f. Nose

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

g. Mouth / Throat

☐ Normal ☐ Sores ☐ Absence of Taste
☐ Bleeding ☐ Abnormal Taste ☐ Tonsillitis
☐ Enlarged Glands
☐ Other_____

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

☐ Normal ☐ Varicosities ☐ Cough
☐ Murmur ☐ Wheezing ☐ Chest Pain
☐ Palpitations ☐ Blue Extremities ☐ Difficulty Breathing
☐ Swollen Extremities
☐ Other_____

i. Breasts

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

j. Gastrointestinal (Stomach / Digestion)

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

k. Genitourinary

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

l. Endocrine (Metabolism)

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

m. Psychology

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

2 . What hobbies do you participate in?

List Hobbies	Occasionally	Frequently	Constantly
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

What are your habits?

	Never	Packs / Day
Smoking	☐	_____

	Never	Drinks / Day
Alcohol	☐	_____

	Never	Cups-Glasses / Day
Caffeinated Drinks	☐	_____

	Never	Days / week
Exercise	☐	_____

Sleeping Position:

☐ Back
☐ Side
☐ Stomach

	Never	Yes	
Drug / Substance Abuse	☐	☐	*If Yes, discuss with doctor*

Family History: major condition(s) and/or contributory to your condition

_____
_____
_____

Stated Weight: _____lbs Stated Height: _____ Blood Pressure:_____

Occupational & Daily Living Information

1. Job type
   - ☐ Full time ☐ Temporary
   - ☐ Part time ☐ Other _____

2. Workweek
   - Hours per day _____
   - Days per week _____
   - Other _____

3. Do your present complaints affect the number of hours you work per day? ☐ Yes ☐ No

4. Length of time at present occupation_____years, _____months

5. Job involves
   a. Lifting_____lbs
   - ☐ Never ☐ Frequently
   - ☐ Occasionally ☐ Constantly

   b. Additional job requirements
   - ☐ Bending ☐ Twisting ☐ Carrying
   - ☐ Stooping ☐ Turning ☐ Walking
   - ☐ Other_____

6. What is your primary work position / location?
   a. Position
   - ☐ Seated ☐ Standing
   - ☐ Other_____

   b. Location
   - ☐ Desk ☐ Workbench ☐ Counter
   - ☐ Other_____

   c. If seated, what type of chair do you use?
   - ☐ Executive ☐ Steno
   - ☐ Bench ☐ Stool
   - ☐ Other _____

7. Do you wear shoes or boots with high heels?
   - ☐ Never ☐ Seldom
   - ☐ 0ccasionally ☐ Frequently

8. Are you right or left-handed?
   - ☐ Left ☐ Right

9. Do work activities aggravate your present complaints?
   - ☐ Yes ☐ No

10. Which of the following best describes your stress level?
    - ☐ None ☐ Minimal
    - ☐ Moderate ☐ Great

11. 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

Medical History

1. Health Care
   a. Have you been to a Chiropractor ☐ Yes ☐ No

   b. Do you have a family physician ☐ Yes ☐ No
   Date of last physical exam _____
   Physician's name and address
   _____
   _____
   _____

   c. Have you been hospitalized in the last 5 years? ☐ Yes ☐ No
   Date & reason for hospitalization _____
   _____

   d. Have you had surgery in the last 5 years? ☐ Yes ☐ No
   Date & reason for surgery _____
   _____

   e. Have you had a serious accident In the past 5 years? ☐ Yes ☐ No
   ☐ Auto ☐ Work ☐ Home
   ☐ Other _____
   List date & describe injury _____
   _____

   f. Do you have any drug allergies ☐ Yes ☐ No
   List drugs _____

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