Confidential Patient Case History

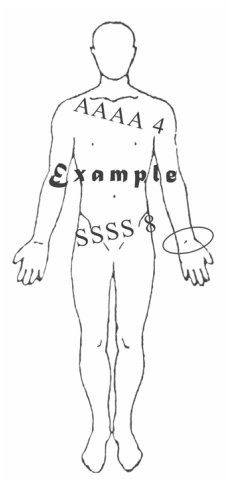
Name _____ Today's Date _____ Home Phone _____
Address_____ City_____ State _____ Zip _____ Work Phone_____
Date of Birth_____Age_____ □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed Cell Phone _____
Occupation _____ Referred By: _____ No. of Children_____
E-mail:_____

Complaints

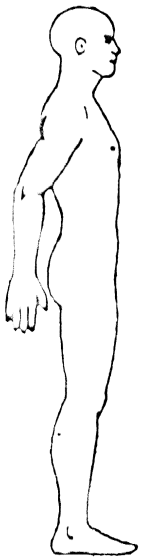
Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

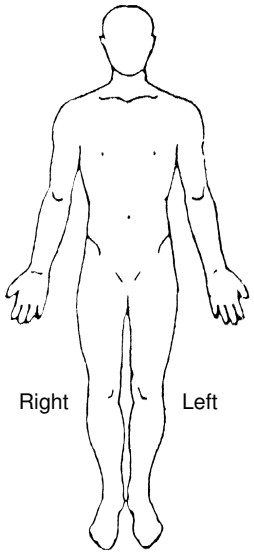
Description ……	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol ……..	NNNN	PPPP	BBBB	AAAA	SSSS

Circle any area of pain not represented by a symbol

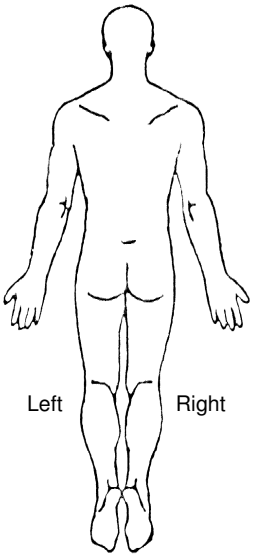


Example

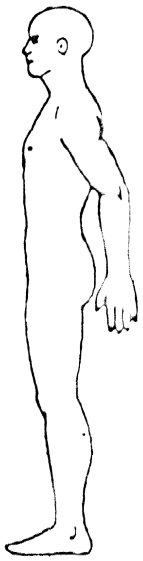

Right



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?
□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
No pain Worst

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		

JOEL KLEIN, D.C.
100 QUAKER LANE
VILLANOVA, PA 19085
(610) 525-2209

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

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

e. Ears

	Right	*Left*
☐ 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	<1	Packs / Day 1-2	2-3	3-4	5+
Smoking	☐	☐	☐	☐	☐	☐

	Never	<1	Drinks / Day 1-2	2-3	3-4	5+
Alcohol	☐	☐	☐	☐	☐	☐

	Never	<1	Cups-Glasses / Day 1-2	2-3	3-4	5+
Caffeinated Drinks	☐	☐	☐	☐	☐	☐

	Never	<1	Days / week 1-2	2-3	3-4	5+
Exercise	☐	☐	☐	☐	☐	☐

	Never	Yes	
Drug / Substance Abuse	☐	☐	*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

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?
   - □ Right □ Left

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
   - □ Anti-inflammatory (Aspirin, Motrin, etc.)
   - □ Muscle Relaxants □ Pain medication / analgesic
   - □ Tranquilizers □ Antibiotics
   - □ Blood pressure pills □ Birth control pills
   - □ Other _____

   For what conditions are you taking medication? _____
   _____

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	□	□	Sexually Transmitted Disease
□	□	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
□	□	High Blood Pressure	□	□	Multiple Sclerosis
□	□	Low Blood Pressure	□	□	Scoliosis
□	□	Heart Trouble	□	□	Mental / Emotional Difficulty
□	□	Pacemaker	□	□	Prostate Trouble
□	□	HIV	□	□	Kidney Trouble
□	□	AIDS	□	□	Other_____
□	□	Other_____	□	□	Other_____

Insurance Information

Auto Related □ Yes □ No
Work Related □ Yes □ No

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