Patient Case History

Rev.11/12

Name _____ Birthdate _____ SSN _____
Street _____ City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____ Mobile Phone _____
Email (for our use only!) _____ Referred by: _____
Marital Status: Single / Married / Widowed Spouse _____
Emergency Contact _____ Relationship _____ Phone # _____
Primary Language _____ Ethnicity_____ Race_____
Your Occupation _____
Your Employer _____
Insured Name _____Insured Birthdate _____Insured SSN _____
Insured's Employer _____

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), **circle** the number that best reflects your condition: ↓none to severe↓	Please check the box below that best represents how much of the time you feel pain or note symptom(s) for the listed reason:
1.		0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
2.		0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
3.		0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
4.		0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

For each of the reasons or conditions listed above, please mark how it happened:

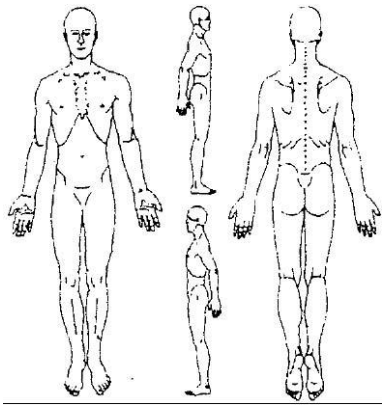
1. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto Accident ☐ Other _____ ☐ I don't know
2. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto Accident ☐ Other _____ ☐ I don't know
3. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto Accident ☐ Other _____ ☐ I don't know
4. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto Accident ☐ Other _____ ☐ I don't know

For each of the reasons or conditions listed above, please check if it is better or worse with any of the following:

	HEAT		**COLD**		**REST**		**ACTIVITY**		**OTHER**		(please describe on line below)
	better	worse	better	worse	better	worse	better	worse	better	worse	
Reason 1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Reason 2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Reason 3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Reason 4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____

Please **mark** the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ sharp or stabbing
ooo pins and needles
vvv dull or aching
/// numbness



During what time of the day do you feel worse? _____
Do you sleep well? Yes / No What are your normal sleeping hours? _____ to _____

Medical History

Height _____ Weight _____ Family Doctor _____
Medications (Attach list if necessary) _____
Supplements (Attach list if necessary) _____
Surgeries (Year) _____
Allergies _____
Are you dairy or gluten sensitive? Yes / No *If you are female, are you pregnant? Yes / No
Are you currently under the care of a medical doctor or other type of health care provider for any condition(s)? Yes / No
If yes, what condition(s)? _____
Name of doctor/provider _____ Phone_____
Do you exercise? Yes / No *If yes, please describe activity _____
Intensity_____ How many days a week? _____ How many minutes per session? _____
Do you use?(how often) ❑ Alcohol (_____) ❑ Tobacco (_____) ❑ Coffee (_____) ❑ Soft Drinks (_____) ❑ Pain Relievers (_____)

Personal History

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ❑ Neck pain with difficulty swallowing
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

Types of pain

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102° F
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Headaches
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury
- ❑ Night sweats

Previously diagnosed condition/medical history

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as from chemotherapy, organ transplant, etc.
- ❑ Three or more months use of steroid medications or intravenous drugs (past or recent)
- ❑ Osteoporosis

Review of Symptoms

Are you suffering from any of the symptoms below?

Skin:	❑ Rash	❑ Redness	❑ Itching	❑ Mole changes	❑ Nail changes	❑ Hair changes	
Ear, Eyes, Nose, Throat:	❑ Vision problems	❑ Ringing ears	❑ Hearing Loss	❑ Nose bleeds	❑ Decreased smell or taste	❑ Bleeding gums	
Heart/Lungs:	❑ Cough	❑ Wheezing	❑ Shortness of breath	❑ Swollen hands/feet	❑ Chest pain	❑ Palpitations	
Digestion:	❑ Decreased appetite	❑ Abdominal pain	❑ Vomiting	❑ Diarrhea	❑ Constipation	❑ Rectal bleeding	
Urinary/ Reproductive:	❑ Urgent urination	❑ Painful urination	❑ Frequent urination	❑ Bloody urine	❑ Abnormal vaginal bleeding	❑ Abnormal menstruation	❑ Impotence
Endocrine:	❑ Heat/cold intolerance	❑ Tremors	❑ Excessive thirst	❑ Fatigue			
Breast:	❑ Lumps	❑ Dimpling	❑ Discharge				

Family History

- ❑ Autoimmune disorders
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease
- ❑ Kidney disease
- ❑ Mental illness
- ❑ Seizure disorder
- ❑ Stroke
- ❑ Anemia

I hereby authorize the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, chiropractic care or any clinic services that he deems necessary in my case. The nature and purpose of the procedures, possible alternatives and possibility of complications will be explained to me by the doctor. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure will be given by the doctor. I furthermore authorize him to disclose all or any part of my patient record to any person or corporation, as required by law, or to my health insurance company or worker's compensation carrier in the processing of medical claims on my behalf. I acknowledge that any insurance I have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ _____ _____
Patient/Guardian Signature Date Doctor's Initials