Today's Date: ____________

Introduction Patient Case History

Patient Information

Name (First, MI, Last)			Preferred Name
Address		City	State/Zip
Home Phone	Mobile Phone	Mobile Carrier	Work Phone
Email		Gender ○M ○F ○Other	Marital Status ○Single ○Married ○Other
Social Security #	Date of Birth	Employed ○Yes ○No	Student Status ○Full-time ○Part-time ○Not applicable

Ethnicity ○Hispanic or Latino ○ Not Hispanic or Latino ○Decline

Preferred Language ○English ○Decline ○ Other

Race ○Asian ○ African American ○American Indian or Alaska Native ○Native Hawaiian or Pacific Islander ○White ○Decline ○Other

Referred by (Name) ○Family ○ Friend ○Co-worker ○ Doctor ○Other source

Emergency Contact Information

Name (First, MI, Last)			Relationship ○Child ○ Parent ○ Spouse ○Other
Home Phone	Mobile Phone	Primary Care Physician	Physician Phone

Financial Information

○Insurance ○ Worker's Comp ○ Self-pay (cash) ○Personal Injury/Auto ○Other (please explain)

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Name		Insurance Name	
Relationship to Insured ○Self ○ Spouse ○Parent ○Child ○Other		Relationship to Insured ○Self ○ Spouse ○Parent ○Child ○Other	
Insureds Name	Gender ○M ○F ○Other	Insureds Name	Gender ○M ○F ○Other
Address		Address	
City/State/Zip		City/State/Zip	
Phone	Date of Birth	Phone	Date of Birth

Responsible Party

Who is responsible for payment? ○Self ○ Other (Relationship)

Name (First, MI, Last)		Phone
Address	State	Zip
Phone	Email	

It is usual and customary to pay for services as rendered unless otherwise arranged.

Patient No: ____________

GILMORE CHIROPRACTIC

Patient Case History

History of Current Condition

Describe Major Complaint

Describe any Secondary Complaints

Describe WHEN and HOW this began

Grade Intensity/Severity of Complaint ○ None (0) ○ Mild (1-2) ○ Mild-Moderate (2-4) ○ Moderate (4-6) ○ Moderate - Severe (6-8) ○ Severe (8-10)

Quality of Complaint/pain ○ Sharp ○ Stabbing ○ Burning ○ Achy ○ Dull ○ Stiff & Sore ○ Other

How frequent is the complaint present? ○ Off and On ○ Constant

Does this complaint radiate/shoot to any areas of your body? ○ No ○ Yes (Describe)

Head ○ Base of Skull ○ Forehead ○ Sides/Temple ○ Right Side ○ Left Side ○ Both Sides
Arm ○ Across Shoulder ○ Elbow ○ Hand-Fingers ○ Right Side ○ Left Side ○ Both Sides
Leg ○ Hip/Thigh ○ Calf ○ Foot-Toes ○ Right Side ○ Left Side ○ Both Sides
Other Area

Does anything make the complaint better? ○ Ice ○ Heat ○ Rest ○ Movement ○ Stretching ○ OTC meds ○ Other

Does anything make the complaint worse? ○ Sit ○ Stand ○ Walk ○ Lying ○ Sleep ○ Overuse ○ Other

Which daily activities are being affected by this condition? (Describe)

For this CURRENT condition have you...

Received any other treatment? ○ None ○ DC ○ MD ○ PT ○ Massage ○ ER ○ Other **Where?**

Had any diagnostic testing? ○ X-rays ○ MRI ○ CT ○ Other When and **Where?**

Health History *(Please use the reverse side of this page if additional space is needed)*

MEDICATIONS AND SUPPLEMENTS

ALLERGIES TO MEDICATIONS	○ NONE
NAME	REACTION

CURRENT MEDICATIONS & SUPPLEMENTS		○ NONE	
NAME	DOSAGE	FREQUENCY	METHOD

PAST HEALTH HISTORY

NUMBER OF FALLS IN LAST 24 MONTHS INJURIES? ○ Yes ○ No

SURGERIES		○ NONE
DATE	AREA OF BODY	REASON

MAJOR INJURIES/TRAUMAS/HOSPITALIZATIONS	○ NONE
DATE	DESCRIBE

FAMILY HEALTH HISTORY (LIST RELEVANT MAJOR PROBLEMS OF FIRST DEGREE RELATIVES)

PROBLEM	PARENT (M OR F)	SIBLING (B OR S)	CHILD (S OR D)

SOCIAL AND OCCUPATIONAL HISTORY

SMOKING ○ EVERY DAY ○ SOME DAYS ○ FORMER ○ NEVER

HABIT	TYPE	AMOUNT	YEAR STARTED
SMOKING			
TOBACCO			
ALCOHOL			
CAFFEINE			
REC. DRUGS			

EDUCATION ○ HIGH SCHOOL ○ COLLEGE GRAD ○ POST GRAD ○ OTHER

LIFESTYLE	DESCRIBE
HOBBIES	
RECREATION	
EXERCISE	
DIET	
WORK	
OTHER	

Patient No: ______________

Review of Systems

Are you CURRENTLY experiencing any of these symptoms? (Check all that apply)

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General *(Constitutional)*

- ○ Recent Weight Change
- ○ Fever
- ○ Fatigue
- ○ None in this category

Musculoskeletal

- ○ Low Back Pain
- ○ Mid Back Pain
- ○ Neck Pain
- ○ Arm Problems (explain)
- ○ Leg Problems (explain)
- ○ Painful Joints
- ○ Stiff/Swollen Joints
- ○ Sore/Weak Muscles or Joints
- ○ Muscle Spasms/Cramps
- ○ Broken Bones
- ○ Other (explain)
- ○ None in this category

Neurological

- ○ Numbness or Tingling Sensations
- ○ Loss of Feeling
- ○ Dizziness or Light Headed
- ○ Frequent or Recurrent Headaches
- ○ Convulsions or Seizures
- ○ Tremors
- ○ Stroke
- ○ Other (explain)
- ○ None in this category

Mind/Stress

- ○ Nervousness
- ○ Depression
- ○ Sleep Problems
- ○ Memory Loss or Confusion
- ○ Other (explain)
- ○ None in this category

Genitourinary

- ○ Sexual Difficulty
- ○ Kidney Stones
- ○ Burning/Painful Urination
- ○ Change in Force/Strain with Urination
- ○ Frequent Urination
- ○ Blood in Urine
- ○ Incontinence or Bed Wetting
- ○ Other (explain)
- ○ None in this category

Gastrointestinal

- ○ Loss of Appetite
- ○ Blood in Stool
- ○ Change in Bowel Movements
- ○ Painful Bowel Movements
- ○ Nausea or Vomiting
- ○ Abdominal Pain
- ○ Frequent Diarrhea
- ○ Constipation
- ○ Other (explain)
- ○ None in this category

Cardiovascular & Heart

- ○ Chest Pains
- ○ Rapid or Heartbeat Changes
- ○ Blood Pressure Problems
- ○ Swelling of Hands, Ankles or Feet
- ○ Heart Problems
- ○ Other (explain)
- ○ None in this category

Respiratory

- ○ Difficulty Breathing
- ○ Persistent Cough
- ○ Coughing Blood
- ○ Asthma or Wheezing
- ○ Lung Problems
- ○ Other (explain)
- ○ None in this category

Eyes and Vision

- ○ Wear Contacts/Glasses
- ○ Blurred or Double Vision
- ○ Glaucoma
- ○ Eye Disease or Injury
- ○ Other (explain)
- ○ None in this category

Ear, Nose and Throat

- ○ Bleeding Gums/Mouth Sores
- ○ Bad Breath or Bad Taste
- ○ Dental Problems
- ○ Swollen Throat or Voice Change
- ○ Swollen Glands in Neck
- ○ Ringing in the Ears
- ○ Ear - Ache/Ringing/Drainage
- ○ Sinus/Allergy Problems
- ○ Nose Bleeds
- ○ Hearing Loss
- ○ Other (explain)
- ○ None in this category

Endocrine, Hematologic and Lymphatic

- ○ Thyroid Problems
- ○ Diabetes
- ○ Excessive Thirst or Urination
- ○ Cold Extremities
- ○ Heat or Cold Intolerance
- ○ Change in Hat or Glove Size
- ○ Dry Skin
- ○ Glandular or Hormone Problem
- ○ Swollen Glands
- ○ Anemia
- ○ Easily Bruise or Bleed
- ○ Phlebitis
- ○ Transfusion
- ○ Immune System Disorder
- ○ Other (explain)
- ○ None in this category

Skin and Breasts

- ○ Rash or Itching
- ○ Change in Skin Color
- ○ Change in Hair or Nails
- ○ Non-healing Sores
- ○ Change of Appearance of a Mole
- ○ Breast Pain
- ○ Breast Lump
- ○ Breast Discharge
- ○ Other (explain)
- ○ None in this category

WOMEN ONLY

ARE YOU PREGNANT?

○ Yes Due Date ______________________________

○ No Last Menstrual Period ______________________________

- ○ Infertility
- ○ Painful or Irregular Periods
- ○ Vaginal Discharge
- ○ Other (explain)
- ○ None in this category

PREGNANCIES

Date	Outcome

Comments ____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature ____ **Date** ______________

Treating Doctor Signature ____ **Date** ______________

Patient No: ______________