



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 <input type="radio"/> M <input type="radio"/> F <input type="radio"/> Other	Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Other
Social Security #	Date of Birth	Employed <input type="radio"/> Yes <input type="radio"/> No	Student Status <input type="radio"/> Full-time <input type="radio"/> Part-time <input type="radio"/> Not applicable
Ethnicity <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Decline		Preferred Language <input type="radio"/> English <input type="radio"/> Decline <input type="radio"/> Other	
Race <input type="radio"/> Asian <input type="radio"/> African American <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Native Hawaiian or Pacific Islander <input type="radio"/> White <input type="radio"/> Decline <input type="radio"/> Other			
Referred by (Name)		<input type="radio"/> Family <input type="radio"/> Friend <input type="radio"/> Co-worker <input type="radio"/> Doctor <input type="radio"/> Other source	

Emergency Contact Information

Name (First, MI, Last)		Relationship <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Spouse <input type="radio"/> 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 <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Child <input type="radio"/> Other		Relationship to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Child <input type="radio"/> Other	
Insureds Name	Gender <input type="radio"/> M <input type="radio"/> F <input type="radio"/> Other	Insureds Name	Gender <input type="radio"/> M <input type="radio"/> F <input type="radio"/> 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: _____

History of Current Condition

Describe Major Complaint

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 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 previous surgery or interventions in this area? (Describe)

Taken any medications Over the counter Prescriptions (List)

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

Describe any Secondary Complaints

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

SURGERIES NONE

DATE	AREA OF BODY	REASON

MAJOR INJURIES/TRAUMAS/HOSPITALIZATIONS NONE

DATE	DESCRIBE

FAMILY HEALTH HISTORY (PLEASE MARK N/A IF NOT RELEVANT)

List relevant major health problems of immediate relatives

Deaths in immediate family (cause and what age?)

PRENATAL HISTORY HOME BIRTHING CENTER HOSPITAL

BIRTH WEIGHT BIRTH LENGTH

INTERVENTION NONE FORCEPS VACUUM C-SECTION

COMPLICATIONS (DESCRIBE) NONE

MEDICATIONS DURING PREGNANCY (LIST) NONE

FEEDING AND DEVELOPMENT HISTORY

BREAST FED YES NO HOW LONG?

FORMULA YES NO WHAT TYPE?

FOOD ALLERGIES OR INTOLERANCES YES NO (IF YES, DESCRIBE)

ROLLING OVER YES NO SITTING YES NO

CRAWLING YES NO WALKING YES NO

SLEEP (HOURS PER NIGHT) SLEEP WELL YES NO

CHILDHOOD DISEASES NONE CHICKEN POX MEASLES MENINGITIS MUMPS
 WHOOPING COUGH RUBELLA OTHER (NAME)

HAS CHILD BEEN VACCINATED? YES NO ADVERSE REACTIONS? YES NO

SOCIAL AND OCCUPATIONAL HISTORY

LEVEL OF EDUCATION COMPLETED

LIFESTYLE (LIST HOBBIES, RECREATION, ACTIVITIES, EXERCISE, DIET, WORK VITAMINS)

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: _____