INTRODUCTION PATIENT CASE HISTORY

PATIENT INFORMATION					
Name: (First MI Last)				Preferred	Name:
Address:		City	y :	State:	Zip:
Date of Birth:	Gender: 🗆 M	ale Female		Social Security #:	
Home:	Mobile:	Wo	rk:		
Email:					
Preferred Method of Conta	ct: Text	Email	Home Phone	☐ Other:	
*Referred By: (Name)					
☐ Family ☐ Friend	☐ Co-Worker	□ Doctor □			
Race & Ethnicity: (Choose up		Preferred I			
☐ African American or Bla	ack	English	1		
☐ American Indian or Alas	skan Native		h		
☐ Asian		Other:			
☐ Hispanic or Latino		☐ Decline	e		
☐ Native Hawaii or Other	Pacific Islander				
□ White					
☐ Decline					
EMERGENCY CONTACT INFORMATION					
Name: (First MI Last)			Primary C	Care Physician:	
Home:	Mobile:		Doctor's P	Phone:	
Relationship: ☐ Child ☐ Parent ☐ S	nouse				
Clilid Falent S	-				
INANCIAL INFORMATION					
Is today's visit the result of a	n accident?		Where wo	uld you like statement	s sent?
□ No □ Auto □ W	ork			☐ Other (Details below	<i>y</i>)
Will we be working with insu	ırance? 🗆 No	Yes (Details)	Name:		·
Primary:			Address:		
Secondary:			Phone:	Email:	

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

HISTORY OF PRESENT ILLNESS

Major Complaint:		Secondary Complaints:		
When did it start?/ Wh	at happened?			
Which daily activities are being affected b	oy this condition?			
	MAJOR COMPL	<u>AINT</u>		
Location of Symptoms and Radiation	Quality:	Previous Treatment:		
	□ Sharp	None		
	☐ Stabbing	Chiropractor		
(\frac{1}{2} \frac{1}{2} \frac	☐ Stationing ☐ Burning	☐ Medical Doctor		
R) Jajana (pt)	☐ Achy	□ Physical Therapy		
		□ ER/Urgent Care		
	☐ Stiff & Sore	□ Orthopedic		
	Other:	-		
()(1)	Does it radiate?	Previous Diagnostic Testing:		
R L L R	□ No □ Yes (Please indicate)			
		X-rays		
P Pain T Tender	Improves with:	□ MRI		
N Numb H Hypoesthesia S Spasm	☐ Heat	□ CT		
Grade Intensity/Severity:	☐ Movement	Other:		
□ None (0/10)	□ Stretching	*Women: Are you pregnant?		
□ Mild (1-2/10)	☐ OTC Medications:			
☐ Mild-Moderate (2-4/10)	Other:			
☐ Moderate (4-6/10)	Worsens with:	Present Illness Comments:		
☐ Moderate-Severe (6-8/10)	_ ~	Tresent timess Comments.		
□ Severe (8-10/10)	☐ Sitting☐ Standing/Walking			
Frequency:	☐ Lying Down/Sleeping			
□ Off & On	☐ Overuse/Lifting			
□ Constant	Other:			
Prescription Medications & Supplements:	: □ None Al	lergies to Medications: ☐ No known drug allergies		
Yes (List – Name, dosage, frequency)		Yes (List - Name and reaction)		
		. ,		
				

PAST, FAMILY, AND SOCIAL HISTORY

									to elaborate.)	Medical History Comments
llnesses: □ Asthma			ŀ	Iospita	anzau	ons: (N	on-surg	ical witi	n Date)	Medical History Comments:
☐ Autoimmune Disorder (7)	уре)									
☐ Blood Clots										
Cancer (<i>Type</i>)			S	_		_			gery date)	
CVA/TIA (stroke)				□ Ca	ncer _					
DiabetesMigraine Headaches				Ort			D / I			
Osteoporosis				Elbo	SHOU w/Fore	naer – earm –	R/L			
Other:										
						Hip –	R/L			
					I	Knee –	R/L			
ninniag.							R/L			
ijuries: ∃ Back Injury				☐ Spi						
☐ Broken Bones				F	ack:					
☐ Head Injury										
□ Neck Injury				Otl	ner:					
☐ Falls										
Other:										
MILY HISTORY (Please mark X to a	all that a	pply an	d use co	mments	to elabo	rate.)				
☐ Unknown ☐ Unrem	arkable	e				•			Family Hi	story Comments:
	her	Jer	ng1	ng2	ng3	d1	d2	d3		
	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3		
Gender	F	M								
Age at death (if Deceased)										
Aneurysms										
CVA (Stroke)										
Cancer	\longrightarrow									
Diabetes										
Heart Disease									-	
									-	
Hypertension										
Hypertension Other Family History										
Other Family History	RY									
Other Family History		ed 🗆 🗆	Divorc	ed 🗆 (Other		Caf	eine U	 Jse:	
Other Family History CIAL AND OCCUPATIONAL HISTOI Marital Status: Single	Marrie									□ Energy Drinks □ Soda □ Never
Other Family History CIAL AND OCCUPATIONAL HISTOR Marital Status: Children: None 1 2	Marrie	4 🗆	Other:					Coff	fee 🗆 Tea	□ Energy Drinks □ Soda □ Never
Other Family History CIAL AND OCCUPATIONAL HISTOR Marital Status: Single Children: None Full Student Status: Full Student Status: Other Family History	Marrie ☐ 3 ☐ lent ☐ 1	□ 4 □ Part S	Other:	□ Nor	n-Stude	ent	Exe	Coff	fee Tea	
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Other Family History CAL AND OCCUPATIONAL HISTOR Marital Status: Single Children: None 1 2 Student Status: Full Stud Highest level of Education: Post Grad. Other:	Marrie ☐ 3 ☐ lent ☐ l ☐ Hig	□ 4 □ Part S gh Scl	Other: tudent hool	□ Nor	n-Stude	ent d.	Exe	Coff rcise f Dail	fee Tea frequency: y 3-4xs/	week 2-3xs/week Rarely Neve
Other Family History CIAL AND OCCUPATIONAL HISTOR Marital Status: Single Student Status: Full Student Status: Full Student Status: Value S	Marrie 3 lent l Hig	□ 4 □ Part S gh Scl	Other: tudent hool	□ Nor Colleg	n-Stude	ent d.	Exe	Coff rcise f Dail	fee Tea frequency: y 3-4xs/	week 2-3xs/week Rarely Neve
Other Family History CIAL AND OCCUPATIONAL HISTOR Marital Status: Single Student Status: Full Student Status: Full Student Status: Other: Post Grad. Other: Employed: No Yes (Commont Hand: Right	Marrie 3	Part S gh Scl	Other: tudent hool	□ Nor Colleg	n-Stude ge Grae	ent d. 	Exe	Coff rcise f Dail	fee Tea frequency: y 3-4xs/	week 2-3xs/week Rarely Neve
Other Family History CIAL AND OCCUPATIONAL HISTOR Marital Status: Single Student Status: Full Student Status: Full Student Status: Village S	Marrie	Part S gh Scl ion) eft noker, c	Other: tudent hool Amb	□ Nor Colles	n-Stude ge Grae ous	ent d. 	Exe	Coff rcise f Dail	fee Tea frequency: y 3-4xs/	week 2-3xs/week Rarely Neve
Other Family History CIAL AND OCCUPATIONAL HISTOR Marital Status: Single Children: None 1 2 Student Status: Full Student Status: Full Student Status: Vall Student Status: Full	Marrie	Part S gh Scl ion) eft noker, c	Other: tudent hool Amb	□ Nor Colles	n-Stude ge Grae ous	ent d. 	Exe	Coff rcise f Dail	fee Tea frequency: y 3-4xs/	week 2-3xs/week Rarely Neve
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REVIEW OF SYSTEMS

REVIEW OF SYSTEMS

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

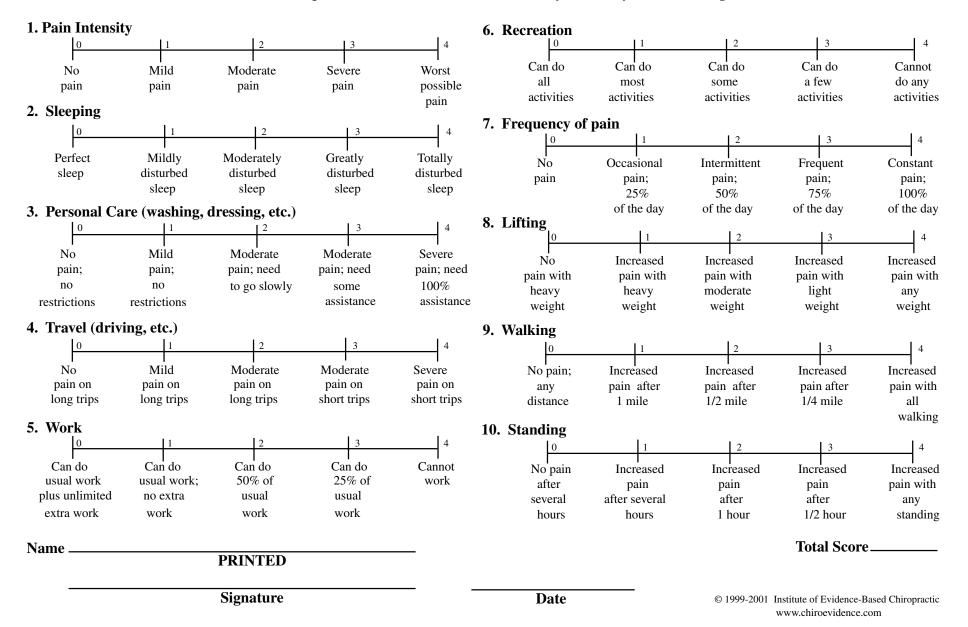
Are you <u>currently</u> experiencing any of these symptoms? (Please select all that apply and use comments to elaborate.)

Constitutional: (General)	Respiratory:	Review of Systems Comments:
☐ Fever	 Difficulty Breathing 	
☐ Fatigue	□ Cough	
Other:	☐ Other:	
□ None in this Category	☐ None in this Category	
Musculoskeletal:	Eyes & Vision:	
☐ Joint Pain/Stiffness/Swelling	Eye Pain	
☐ Muscle Pain/Stiffness/Spasms	☐ Blurred or Double Vision	
☐ Broken Bones	☐ Sensitivity to Light	
Other:	Other:	
☐ None in this Category	☐ None in this Category	-
Neurological:	Head, Ears, Nose, & Mouth/Throat:	
 Dizziness or Lightheaded 	☐ Frequent or Recurrent Headaches	
☐ Convulsions or Seizures	☐ Ear - Ache/Ringing/Drainage	
☐ Tremors	☐ Hearing Loss	
☐ Other:	☐ Sensitivity to Loud Noises	
□ None in this Category	☐ Sinus Problems	
Psychiatric: (Mind/Stress)	☐ Sore Throat	
☐ Nervousness/Anxiety	Other:	
☐ Depression	☐ None in this Category	
☐ Sleep Problems	Endocrine:	
☐ Memory Loss or Confusion	☐ Infertility	
☐ Other:	☐ Recent Weight Change	
☐ None in this Category	Eating Disorder	
Genitourinary:	Other:	
☐ Frequent or Painful Urination	☐ <i>None in this Category</i>	
☐ Blood in Urine	Hematologic & Lymphatic:	
☐ Incontinence or Bed Wetting	Excessive Thirst or Urination	
☐ Painful or Irregular Periods	☐ Cold Extremities	
Other:	☐ Swollen Glands	
□ None in this Category	☐ Other:	
Gastrointestinal:	None in this Category	
□ Loss of Appetite	Integumentary: (Skin, Nails, & Breasts)	
☐ Blood in Stool or Black Stool	Rash or Itching	
□ Nausea or Vomiting	☐ Change in Skin, Hair, or Nails	
☐ Abdominal Pain	□ Non-healing Sores or Lesions	
☐ Frequent Diarrhea	☐ Change of Appearance of a Mole	
☐ Constipation	☐ Breast Pain, Lump, or Discharge	
Other:	Other:	
None in this Category	None in this Category	
Cardiovascular & Heart:	Allergic/Immunologic:	
Chest Pains/Tightness	☐ Food Allergies	
☐ Rapid or Heartbeat Changes	☐ Environmental Allergies	
☐ Swelling of Hands, Ankles, or Feet	Other:	
□ Other:	None in this Category	
□ None in this Category	, , , , , , , , , , , , , , , , , , , ,	
.		
I have answered these questions to the best of	my knowledge and certify them to be true and correc	t.
Patient or Guardian Signature		Date
i attent of Guardian Signature		Datc

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your <u>neck and/or back problems</u> have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**



ACCIDENT/INJURY QUESTIONNAIRE

AUTOMOBILE ACCIDENT – ADDITIONAL	INFORMATION			
• Was anyone else in the vehicl	· — —	** * -		and page and page a
• You were? Front seat – Dr				
• Name of Driver, if not self:				
• Did airbags deploy? ☐ No ☐				
• Did you strike the windshield				
• Were you knocked unconscio				
• Where was your vehicle impa				
• Where was the other vehicle	-			
• Your Auto Ins:	•			
o Address:				
• Other's Auto Ins:				
o Address:		City:	State:	Zip:
WORKER'S COMPENSATION INJURY – AI		anotion.	Claire #	
Employer:				
Address: Contact Person:	•			
GENERAL ACCIDENT/INJURY INFORMA Date of Accident://	Time:: AN	M / PM		
	Time:: AN	M / PM		
Date of Accident://_ Please describe the accident in a Before the accident/injury:	Time:: AN as much detail as possible	Л / РМ •?		
Date of Accident://_ Please describe the accident in a Before the accident/injury: • Have you ever had any con	Time:: AN as much detail as possible	A / PM e? rea before? □ No □ Ye	es	
Date of Accident://_ Please describe the accident in a Before the accident/injury: • Have you ever had any com • If yes - Were they pres	Time:: AN as much detail as possible as much detail as possible applaints in the involved are sent at the time of the acc	A / PM b? rea before? □ No □ Yo ident/injury? □ No □	es	
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Date of Accident:/	Time:: AN as much detail as possible applaints in the involved an sent at the time of the acc e these complaints prior t rming all of your work ac ry: tely after the accident?	A / PM 2?	es Yes on? □ No □ Yes t day □ Next day □] When?
Date of Accident:// Please describe the accident in a Before the accident/injury: • Have you ever had any com • If yes - Were they pres • If yes - Summariz • Were you capable of performs At the time of the accident/injury • Did you feel pain immediat • Were you taken anywhere	Time:: AN as much detail as possible applaints in the involved an sent at the time of the acc e these complaints prior t rming all of your work ac ry: tely after the accident?	I / PM PM PN PN Po Po Po Po Po Po	es Yes on?] When?
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Date of Accident:/	Time: AN as much detail as possible applaints in the involved an sent at the time of the acc the these complaints prior to the trming all of your work acc ry: tely after the accident? We treatment? No Yes mproving? Getting We tricted as a result of this since this accident? In the proving in the prov	rea before? No Ye ident/injury? No to the accident: tivities without restriction No Yes Later that da here? S - (Describe) Vorse? The Same? accident/injury? No No Yes - (Dates?)	es Yes on?] When?