Chiropractic Case History/ Patient Information

Date: _____

Name: _____ Social Security # _____ Home phone: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail address: _____ Cell phone: _____
Age: _____ Birth Date: _____ Race: _____ Marital Status: M S W D
Occupation: _____ Employer: _____
Employers Address: _____ Work phone: _____
Spouse: _____ Occupation: _____ Employer: _____
Number of children: _____ Age(s) of children: _____
_____
Name of nearest relative: _____ Address: _____ Phone: _____
How were you referred to our office? _____
Family Medical Doctor: _____
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at our office? _____

HISTORY OF PRESENT ILLNESS:

Chief complaint: Purpose of this appointment: _____
Date symptoms first appeared or accident happened: _____
Is it getting worse? _____
Is this due to: Auto _____ Work _____ Other _____
Have you ever had the same or similar symptoms? _____ If yes, when and what treatment did you receive:
_____
Days lost from work: _____ Date of last physical exam: _____
Are there any other conditions or symptoms that may be related to your major symptom? _____
If yes, describe _____
Are there other unrelated health problems? Yes No. If yes, describe: _____
_____
Is there anything you can do to relieve the problem? _____
If no, what have you tried that has not helped? _____
Describe the pain: Sharp_____ Dull_____ Numbness _____ Tingling_____ Aching _____
Burning _____ Stabbing_____ Other: _____
Does anything make it worse? _____

Please list any other health problems you have, no matter how insignificant they may seem:

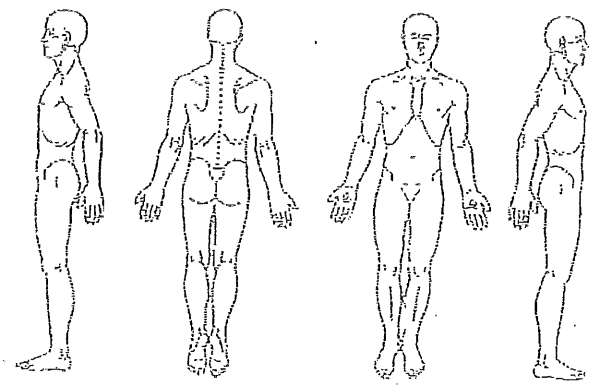
_____
_____
_____
_____
_____

Do you have allergies of any kind? Yes No.
If yes, describe: _____
_____
_____
_____
_____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from (Check all that apply)

___ Broken or Fractured bones
___ Circulatory problems
___ Rheumatoid Arthritis
___ Seizures/Convulsions
___ A Congenital Disease
___ Excessive Bleeding
___ High/Low Blood Pressure
___ Osteoarthritis
___ Epilepsy
___ Pace Maker
___ Strokes
___ Cancer
___ Eating Disorder
___ Coughing Blood
___ Osteoporosis
___ Alcoholism
___ Drug Addiction
___ HIV Positive
___ Gall Bladder
___ Depression

Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? **Women**, please include information about childbirth (include dates): _____

_____

_____

_____

Have you been treated for any health condition by a physician within the last year? _____

_____

_____

What medications or drugs are you taking? _____

_____

_____

SOCIAL HISTORY

Do you drink alcoholic beverages? ____ How much per week? _____
Do you use any tobacco products? ____ Do you smoke? _____ Packs per day: _____
Do you take vitamin supplements? ____ Please list: _____
Do you consume caffeine? _____ How much per day: _____
Do you exercise? _____ What is the frequency and type you do? _____
Hobbies _____

_____

FAMILY HISTORY

Parents:
Father: Living _____ Current age: _____
Deceased _____ Cause of death and age at time of death: _____
Mother: Living _____ Current age: _____
Deceased _____ Cause of death and age at time of death: _____
Check if applicable to you: _____ As an adopted child, little is known of your birth parents or family.
Do you have any family members who suffer from the same condition you do? If so, please list:

_____

FAMILY DISEASES:
(Check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, or **B**rother):

Tuberculosis _____
Diabetes _____
Stroke _____
Arthritis _____
Cancer _____
Asthma _____
Kidney Disease _____
Liver Disease_____
Heart Disease _____
Lung Disease _____
Mental Illness _____

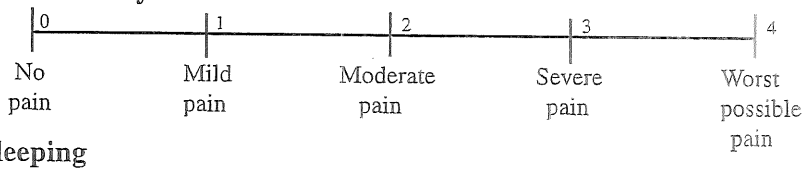
Other: _____

Functional Rating Index

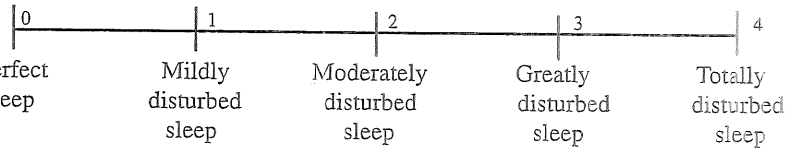
For use with Neck and/or Back Problems only.

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

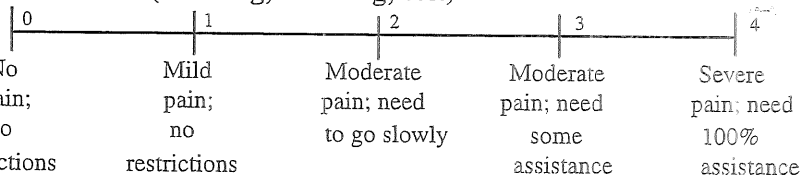
1. Pain Intensity



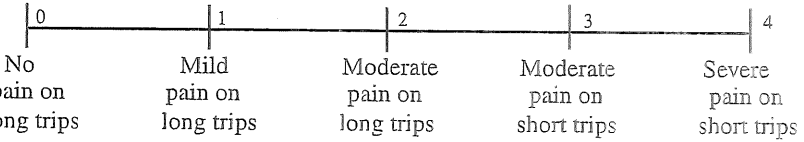
2. Sleeping



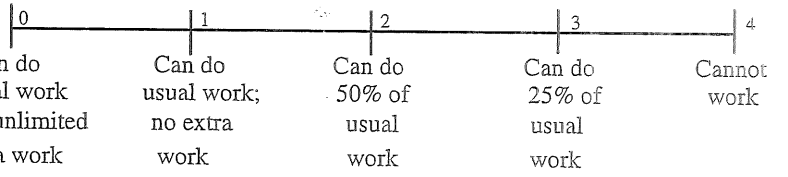
3. Personal Care (washing, dressing, etc.)



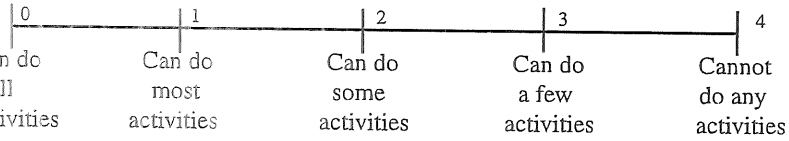
4. Travel (driving, etc.)



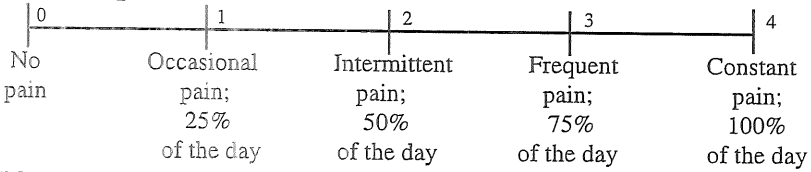
5. Work



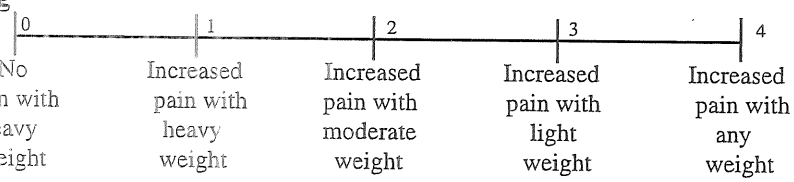
6. Recreation



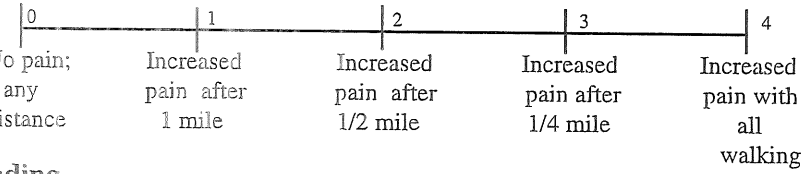
7. Frequency of pain



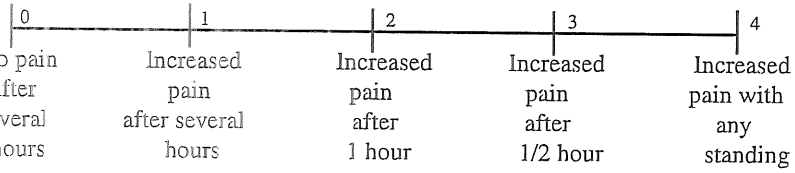
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____