

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI) _____ **Preferred Name:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____
Email: _____ **Gender:** M / F **Marital Status:** Married / Other / Single
Social Security #: _____ **Date of Birth:** _____
Student Status: Full Student / Part Student / Non-Student **Employed** **Employer:** _____
***Referred By:** _____

Ethnicity: Hispanic or Latino / Other **Preferred Language:** _____
Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White **Smoking Status:** Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Primary Care Physician:** _____
Home: _____ **Mobile:** _____ **Doctor's Phone:** _____
Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other (please explain): _____

PRIMARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ **Gender:** M / F
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ **Gender:** M / F
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Date of Birth:** _____

Who is responsible for payment? Self / Other - (*Relationship*) _____

Other than Self:

Full Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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

Patient No: _____

PEDIATRIC CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When? ____/____/____ Describe how this began: _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

How frequent is the complaint present? Off & On / Constant

Does anything make the complaint better? _____

Does anything make the complaint worse? _____

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? OTC / Prescriptions _____

• 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:

Allergies to Medications: *NONE* (List) _____

Current Medications: *NONE*
(Over-the-counter or Prescription.) _____

Past Health History: (Please list any past...)

Surgeries – Date, Type, and Reason: *NONE*

Major Injuries/Traumas: *NONE*

Major Hospitalizations: *NONE*

Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)

Patient No: _____

Prenatal History: Home / Birthing Center / Hospital

Birth Weight: _____ Birth Length: _____

Interventions: *NONE* / Forceps / Vacuum / C-Section

Complications: *NONE* / _____

Medications during pregnancy: *NONE* / _____

Feeding and Development History:

Breast fed: No Yes - How long? _____

Formula: No Yes - What type? _____

Food allergies or intolerances? : No Yes

If yes, please describe: _____

Rolling over: No Yes

Sitting: No Yes

Crawling: No Yes

Walking: No Yes

Sleep: Hours/night _____ Sleep well: No Yes

Childhood diseases: None Chicken Pox Measles

Meningitis Mumps Whooping Cough Rubella

Other: _____

Has child been vaccinated? : No Yes

Any adverse reactions? : No Yes _____

Social and Occupational History:

Level of Education Completed: _____

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

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
Leg Problems
Painful Joints
Stiff/Swollen Joints
Sore/Weak Muscles or Joints
Muscle Spasms/Cramps
Broken Bones
Other:
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
Have you ever had a head injury?
Ever been in an auto accident?
Other:
None in this Category

Mind/Stress:

- Nervousness
Depression
Sleep Problems
Memory Loss or Confusion
Other:
None in this Category

Genitourinary:

- Sexual Difficulty
Kidney Stones
Burning/Painful Urination
Change in force/strain w Urination
Frequent Urination
Blood in Urine
Incontinence or Bed Wetting
Other:
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:
None in this Category

Cardiovascular & Heart:

- Chest Pains
Rapid or Heartbeat changes
Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
Heart Problems
Other:
None in this Category

Respiratory:

- Difficulty Breathing
Persistent Cough
Coughing Blood
Asthma or Wheezing
Lung Problems
Other:
None in this Category

Eyes and Vision:

- Wear contacts/glasses
Blurred or double vision
Glaucoma
Eye disease or injury
Other:
None in this Category

Ears, 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:
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:
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:
None in this Category

Women Only:

Are you pregnant?

- Yes - Due Date
No - Last Menstrual Period

- Infertility
Painful or Irregular periods
Vaginal Discharge
Other:
None in this Category

Pregnancies with Outcome & Date:

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: