

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____/____/____

PATIENT INFORMATION

Name: (First MI Last) _____ Preferred Name: _____

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

Date of Birth: _____ Gender: Male Female Social Security #: _____

Home: _____ Mobile: _____ Work: _____

Email: _____

Preferred Method of Contact: Text Email Home Phone Other: _____

***Referred By:** (Name) _____

Family Friend Co-Worker Doctor Other: _____

Race & Ethnicity: (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaii or Other Pacific Islander
- White
- Decline

Preferred Language:

- English
- Spanish
- Other: _____
- Decline

EMERGENCY CONTACT INFORMATION

Name: (First MI Last) _____

Primary Care Physician: _____

Home: _____ Mobile: _____

Doctor's Phone: _____

Relationship:

Child Parent Spouse Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

No Auto Work Other: _____

Will we be working with insurance? No Yes (Details)

Primary: _____ ID#: _____

Secondary: _____ ID#: _____

Where would you like statements sent?

Self Other (Details below)

Name: _____

Address: _____

Phone: _____ Email: _____

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

Account No: _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: _____

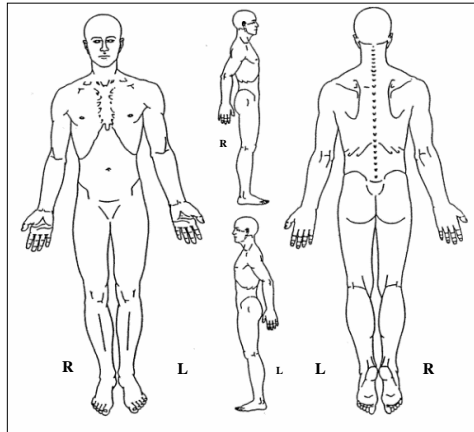
Secondary Complaints: _____

When did it start? ____/____/____ What happened? _____

Which daily activities are being affected by this condition? _____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain T __ Tender
 N __ Numb H __ Hypoesthesia
 S __ Spasm

Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

Frequency:

- Off & On
- Constant

Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: _____

Does it radiate?

- No Yes (Please indicate on drawing)

Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: _____
- Other: _____

Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: _____

Previous Treatment:

- None
- Chiropractor _____
- Medical Doctor _____
- Physical Therapy _____
- ER/Urgent Care _____
- Orthopedic _____
- Other: _____

Previous Diagnostic Testing:

- None
- X-rays _____
- MRI _____
- CT _____
- Other: _____

*Women: Are you pregnant?

- No Last Menstrual Period: ____/____/____
- Yes Due date: ____/____/____

Present Illness Comments:

Prescription Medications & Supplements: None

Yes (List - Name, dosage, frequency) _____

Allergies to Medications: No known drug allergies

Yes (List - Name and reaction) _____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply and use comments to elaborate.)

Illnesses:

- Asthma
- Autoimmune Disorder (Type) _____
- Blood Clots
- Cancer (Type) _____
- CVA/TIA (stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: _____

Hospitalizations: (Non-surgical with Date)

Surgeries: (If yes, provide type & surgery date)

- Cancer _____
- Orthopedic
 - Shoulder – R / L _____
 - Elbow/Forearm – R / L _____
 - Wrist/Hand – R / L _____
 - Hip – R / L _____
 - Knee – R / L _____
 - Ankle/Foot – R / L _____
- Spinal Surgery
 - Neck: _____
 - Back: _____
- Other: _____

Medical History Comments:

Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: _____

FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- Unknown Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: Single Married Divorced Other

Children: None 1 2 3 4 Other: _____

Student Status: Full Student Part Student Non-Student

Highest level of Education: High School College Grad.

Post Grad. Other: _____

Employed: No Yes (Occupation) _____

Dominant Hand: Right Left Ambidextrous

Smoking/Tobacco Use: If current smoker, amount = _____

- Every Day Some Days Former Never

Alcohol Use:

- Every Day Weekly Occasionally Never

Caffeine Use:

- Coffee Tea Energy Drinks Soda Never

Exercise frequency:

- Daily 3-4xs/week 2-3xs/week Rarely Never

Social History Comments: _____

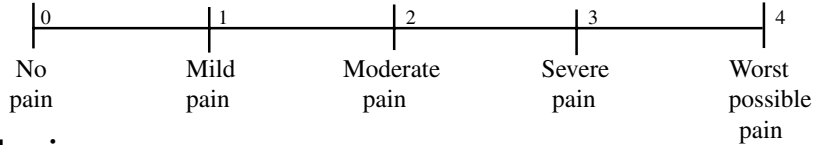
Functional Rating Index

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

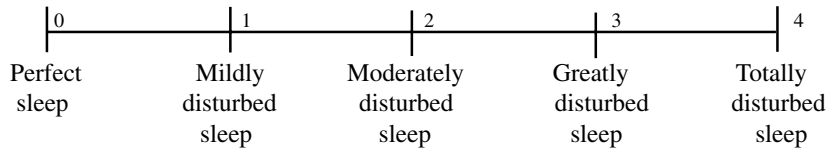
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

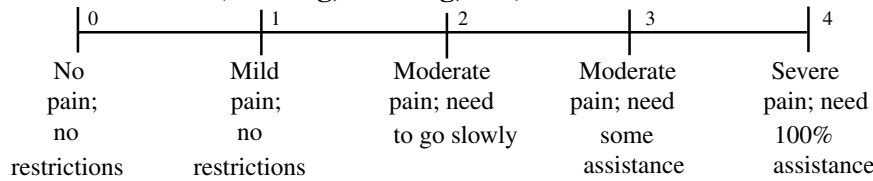
1. Pain Intensity



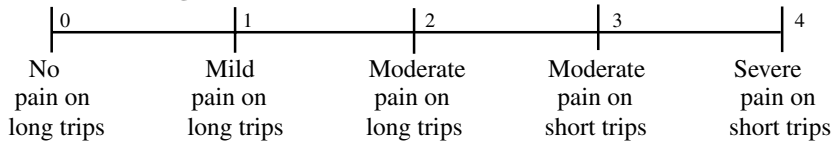
2. Sleeping



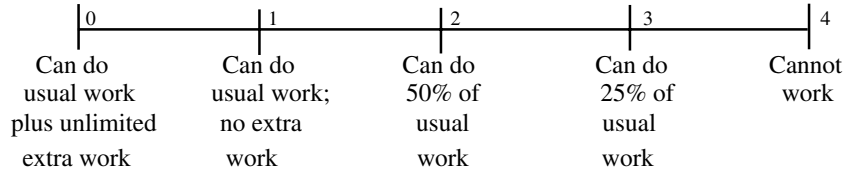
3. Personal Care (washing, dressing, etc.)



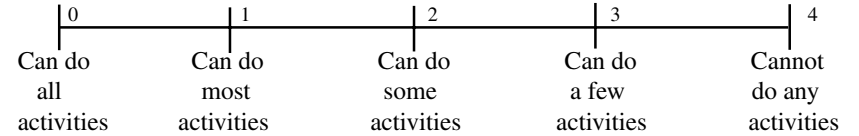
4. Travel (driving, etc.)



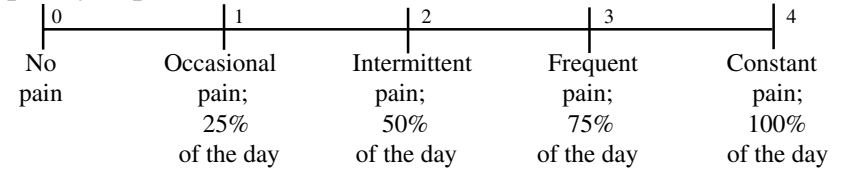
5. Work



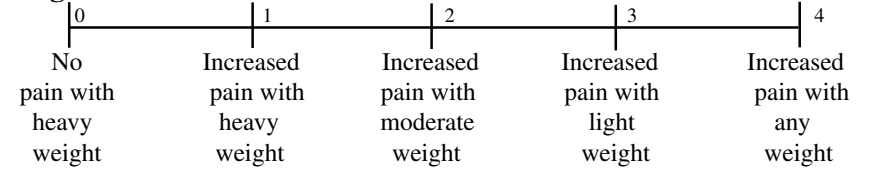
6. Recreation



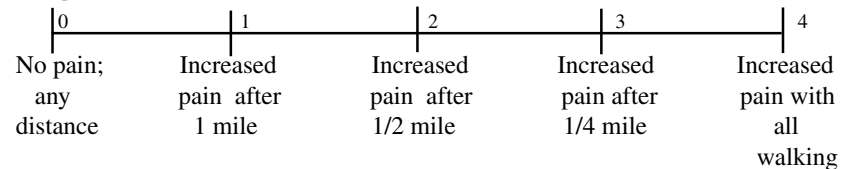
7. Frequency of pain



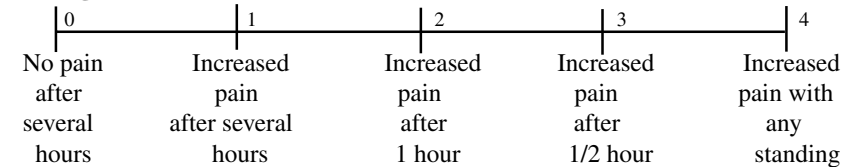
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature

Total Score _____

Date

ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____

Today's Date: _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- Was anyone else in the vehicle with you? No Yes - (Number of people) _____
- You were? Front seat – Driver / Passenger Rear Seat– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- Name of Driver, if not self: _____ Name of Driver of other vehicle: _____
- Did airbags deploy? No Yes Did Police arrive? No Yes Using Seatbelt? No Yes
- Did you strike the windshield or object in car? No Yes - (Describe) _____
- Were you knocked unconscious? No Yes (How long?) _____
- Where was your vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Where was the other vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Your Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____
 - Address: _____ City: _____ State: _____ Zip: _____
- Other's Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____
 - Address: _____ City: _____ State: _____ Zip: _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ Occupation: _____ Claim #: _____
Address: _____ City: _____ State: _____ Zip: _____
Contact Person: _____ Phone: _____ Email: _____

GENERAL ACCIDENT/INJURY INFORMATION – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Date of Accident: ____/____/____ Time: ____:____ AM / PM

Please describe the accident in as much detail as possible? _____

Before the accident/injury:

- Have you ever had any complaints in the involved area before? No Yes
 - If yes - Were they present at the time of the accident/injury? No Yes
 - If yes - Summarize these complaints prior to the accident: _____
- Were you capable of performing all of your work activities without restriction? No Yes

At the time of the accident/injury:

- Did you feel pain immediately after the accident? No Yes Later that day Next day When? _____
- Were you taken anywhere after the accident? No Yes Later that day Next day When? _____
 - If yes, How? _____ Where? _____
 - If yes, Did you receive treatment? No Yes - (Describe) _____

Since the accident/injury:

- Are your symptoms: Improving? Getting Worse? The Same?
- Are your work activities restricted as a result of this accident/injury? No Yes - (How?) _____
- Have you missed any work since this accident? No Yes - (Dates?) _____
- Have you retained an Attorney? No Yes - Name: _____ Phone: _____
 - Address: _____ City: _____ State: _____ Zip: _____

Patient No: _____