

# Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.  
 We want your visit with us to be comfortable, helpful, and educational.

date

**1 PATIENT INFORMATION**

last name

first name

m.i.

**2 HEALTH COMPLAINTS**

Are you here because you were injured while working, in a motor vehicle collision, or in another accident?  yes  no

What services interest you? (mark all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> injury prevention                                 | <input type="checkbox"/> treatment for pain                 | <input type="checkbox"/> patient education classes             |
| <input type="checkbox"/> balance and coordination training                 | <input type="checkbox"/> spinal and body alignment          | <input type="checkbox"/> body composition counseling           |
| <input type="checkbox"/> range of motion, mobility, or flexibility therapy | <input type="checkbox"/> strengthening and stamina exercise | <input type="checkbox"/> nutritional and supplement counseling |
| <input type="checkbox"/> other: <input type="text"/>                       |   |  |

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel?  dull/achy  sharp  numb  tingling  burning  cold

How often do you experience the **primary** complaint?  constantly  daily  weekly  monthly  yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1 no pain or discomfort	2 slight discomfort	3 pain that does not affect my activity	4 pain that affects my daily activities	5 pain that prevents performing my daily activities	6 pain that limits my work schedule	7 pain that prevents working at all	8 pain that prevents working and all personal activity	9 pain that keeps me bed ridden	10 pain that causes thoughts of suicide
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If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

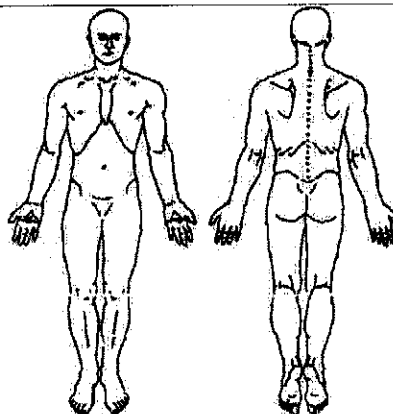
List other health complaints (2-5) on the following lines.

2	4
3	5

Do you have any other condition other than what brings you here?  
 If YES, list it here:

yes  no

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.



- N** = numbness
- T** = tingling
- P** = pain
- W** = weakness

### 3 LIFESTYLES/HABITS

patient name

How many hours of television do you watch a day?  < 1  1-3  3-5  >5

Do you usually snack while watching television?  yes  no

How many hours per day do you use a computer at work or home?  < 1  1-3  3-5  >5

How many hours per day do you ride in a car or other vehicle?  < 1  1-3  3-5  >5

How often do you exercise?  daily  3x's/week  2x's/week  1x/week  I don't exercise

How long do your exercise work outs last?  >1 hour  1 hour  30 minutes  < 30 minutes  NA

What are your exercise activities? (mark all that apply)  I don't exercise

walking  swimming  weight lifting

stretching/flexibility  yoga/Pilates  resistance bands

running/treadmill/rowing/climbing  group exercise classes  other \_\_\_\_\_

Do you take a multi-vitamin?  yes  no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

Have you ever used tobacco?  never  daily  weekly  monthly  yearly

How many servings of alcohol do you drink each week?  0  1-2  3-5  >5

How many servings of coffee do you drink each week?  0  1-2  3-5  >5

How many servings of soda do you drink each week?  0  1-2  3-5  >5

### 4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

condition	n	p	c	mother	n	p	c	father	n	p	c	brother	n	p	c	sister
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
poor conditioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### 5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism <input type="checkbox"/> yes <input type="checkbox"/> no	epilepsy <input type="checkbox"/> yes <input type="checkbox"/> no	low back pain <input type="checkbox"/> yes <input type="checkbox"/> no	polio <input type="checkbox"/> yes <input type="checkbox"/> no
anemia <input type="checkbox"/> yes <input type="checkbox"/> no	goiter <input type="checkbox"/> yes <input type="checkbox"/> no	measles <input type="checkbox"/> yes <input type="checkbox"/> no	rheumatic fever <input type="checkbox"/> yes <input type="checkbox"/> no
appendicitis <input type="checkbox"/> yes <input type="checkbox"/> no	heart disease <input type="checkbox"/> yes <input type="checkbox"/> no	mental disorder <input type="checkbox"/> yes <input type="checkbox"/> no	tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no
arthritis <input type="checkbox"/> yes <input type="checkbox"/> no	HIV positive <input type="checkbox"/> yes <input type="checkbox"/> no	mumps <input type="checkbox"/> yes <input type="checkbox"/> no	venereal infection <input type="checkbox"/> yes <input type="checkbox"/> no
cancer <input type="checkbox"/> yes <input type="checkbox"/> no	influenza <input type="checkbox"/> yes <input type="checkbox"/> no	pleurisy <input type="checkbox"/> yes <input type="checkbox"/> no	whiplash <input type="checkbox"/> yes <input type="checkbox"/> no
	diabetes <input type="checkbox"/> yes <input type="checkbox"/> no	pneumonia <input type="checkbox"/> yes <input type="checkbox"/> no	whooping cough <input type="checkbox"/> yes <input type="checkbox"/> no

## 6 INJURIES

patient name

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

## 7 HOSPITAL/MEDICINE

Have you had breast implant surgery?  yes  no

Have you had knee or hip replacement surgery?  yes  no

Do you have a pacemaker?  yes  no

Do you have any other implantable medical devices in your body?  yes  no

Mark all of the following procedures as they pertain to you.

vaccinations <input type="checkbox"/> yes <input type="checkbox"/> no	tubes in ears <input type="checkbox"/> yes <input type="checkbox"/> no	rectal surgery <input type="checkbox"/> yes <input type="checkbox"/> no
tonsillectomy <input type="checkbox"/> yes <input type="checkbox"/> no	appendectomy <input type="checkbox"/> yes <input type="checkbox"/> no	sinus surgery <input type="checkbox"/> yes <input type="checkbox"/> no
gall bladder removal <input type="checkbox"/> yes <input type="checkbox"/> no	female/male surgery <input type="checkbox"/> yes <input type="checkbox"/> no	hernia surgery <input type="checkbox"/> yes <input type="checkbox"/> no
back surgery <input type="checkbox"/> yes <input type="checkbox"/> no		thyroid surgery <input type="checkbox"/> yes <input type="checkbox"/> no
		stomach surgery <input type="checkbox"/> yes <input type="checkbox"/> no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory?  yes  no Were you ever knocked unconscious?  yes  no

List any broken bones or dislocations that you had.  yes  no

## 8 SYSTEM REVIEW

patient name

Mark the following conditions that are **currently** a cause of significant concern for you.

### General

- |  |                                    |                                       |                                     |  |
|--|------------------------------------|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> consistent fainting | <input type="checkbox"/> chills    | <input type="checkbox"/> convulsions  | <input type="checkbox"/> depression | <input type="checkbox"/> dizziness     |
| <input type="checkbox"/> loss of weight      | <input type="checkbox"/> fatigue   | <input type="checkbox"/> fever        | <input type="checkbox"/> headache   | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> weight gain         | <input type="checkbox"/> neuralgia | <input type="checkbox"/> night sweats | <input type="checkbox"/> wheezing   | <input type="checkbox"/> nervousness   |

### Gastro-Intestinal

- |  |                                   |  |  |   |
|--|-----------------------------------|--|--|---|
| <input type="checkbox"/> constipation    | <input type="checkbox"/> diarrhea | <input type="checkbox"/> gall bladder problems | <input type="checkbox"/> hemorrhoids   | <input type="checkbox"/> jaundice       |
| <input type="checkbox"/> liver problems  | <input type="checkbox"/> nausea   | <input type="checkbox"/> stomach pain          | <input type="checkbox"/> poor appetite | <input type="checkbox"/> poor digestion |
| <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | <input type="checkbox"/> vomiting blood        |  |   |

### Eye/Ear/Nose/Throat

- |  |   |   |                                      |  |
|--|---|---|--------------------------------------|--|
| <input type="checkbox"/> asthma            | <input type="checkbox"/> crossed eyes     | <input type="checkbox"/> deafness       | <input type="checkbox"/> earache     | <input type="checkbox"/> ear discharge |
| <input type="checkbox"/> ear noises        | <input type="checkbox"/> enlarged thyroid | <input type="checkbox"/> frequent colds | <input type="checkbox"/> hay fever   | <input type="checkbox"/> hoarseness    |
| <input type="checkbox"/> nasal obstruction | <input type="checkbox"/> nose bleeds      | <input type="checkbox"/> pain in eyes   | <input type="checkbox"/> poor vision | <input type="checkbox"/> sinusitis     |
| <input type="checkbox"/> sore throat       | <input type="checkbox"/> tonsillitis      |   |                                      |  |

### Respiratory

- |                                     |  |   |   |  |
|-------------------------------------|--|---|---|--|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> chronic cough | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> spitting blood | <input type="checkbox"/> spitting phlegm |
|-------------------------------------|--|---|---|--|

### Muscles/Joints/Bones

- |   |   |  |   |                                     |
|---|---|--|---|-------------------------------------|
| <input type="checkbox"/> backache         | <input type="checkbox"/> foot problems  | <input type="checkbox"/> pain bet. shoulders | <input type="checkbox"/> painful tailbone | <input type="checkbox"/> stiff neck |
| <input type="checkbox"/> spinal curvature | <input type="checkbox"/> swollen joints | <input type="checkbox"/> tremors             | <input type="checkbox"/> twitching        | <input type="checkbox"/> weakness   |

### Cardio-Vascular

- |   |  |   |  |  |
|---|--|---|--|--|
| <input type="checkbox"/> ankle swelling   | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> heart trouble | <input type="checkbox"/> pain over heart |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> rapid heart         | <input type="checkbox"/> slow heart         | <input type="checkbox"/> strokes       |  |

### Skin or Allergies

- |   |                                  |                                 |                                |                                  |
|---|----------------------------------|---------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> bruise easily  | <input type="checkbox"/> dryness | <input type="checkbox"/> eczema | <input type="checkbox"/> hives | <input type="checkbox"/> itching |
| <input type="checkbox"/> sensitive skin |                                  |                                 |                                |                                  |

### Women

- |                                 |   |                                      |  |  |
|---------------------------------|---|--------------------------------------|--|--|
| <input type="checkbox"/> cramps | <input type="checkbox"/> excessive flow | <input type="checkbox"/> hot flashes | <input type="checkbox"/> irregular cycle | <input type="checkbox"/> painful periods |
|---------------------------------|---|--------------------------------------|--|--|

## 9 PREGNANCY

### WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant?  yes  no

On what date did your last period begin?

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date