

Patient Case History

Name _____ Date of Birth _____
 Street _____ City _____ State _____ ZIP _____
 Home Phone _____ Cell Phone _____ Alt Phone _____
 Email address (*office use only!*) _____ Referred by _____
 Marital Status: Single / Married Spouse _____ Phone # _____
 Emergency Contact _____ Relationship _____ Phone # _____
 Your Occupation _____ Employer _____
 Insurance Name _____
 Insured Name _____ Relationship _____
 Insured Birthdate _____

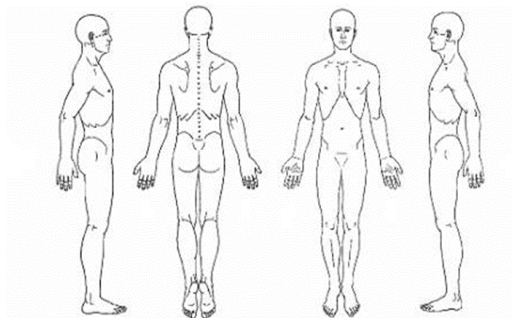
Please list your reason(s) for this visit or your condition(s) in order of importance	Date you first noticed	Using a scale in which "0" is no pain or symptoms and "10" is severe pain or symptoms, circle the number that best reflects your condition:	Please check the box below that best represents how much of the time you feel pain or note symptoms for the listed reason:
		none to severe	
1.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
2.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
3.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
4.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%

For each of the reasons or conditions listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER		(please describe on line below)
	better	worse	better	worse	better	worse	better	worse	better	worse	
Reason 1	___	___	___	___	___	___	___	___	___	___	_____
Reason 2	___	___	___	___	___	___	___	___	___	___	_____
Reason 3	___	___	___	___	___	___	___	___	___	___	_____
Reason 4	___	___	___	___	___	___	___	___	___	___	_____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

- +++ sharp or stabbing
- ooo pins and needles
- vvv dull or aching
- /// numbness



During what time of the day do you feel worse? _____

Do you sleep well? Yes / No What are your normal sleeping hours? _____ to _____

Medical History

Patient Name _____

Height _____ Weight _____ Family Doctor _____ Phone _____

Medication list (attach list if necessary) _____

Supplements (attach list if necessary) _____

Surgeries (year) _____

Allergies _____

Are you dairy sensitive? Yes / No _____ *If you are female, are you pregnant? Yes / No Due date _____

Are you currently under the care of a medical doctor or other type of health care provider for any condition? Yes / No _____

If yes, what is the condition(s)? _____

Name of doctor or provider _____ Phone _____

Do you exercise? Yes / No * If yes, please describe the activity _____

Intensity _____ How many days a week? _____

Do you use? (how often per day or month) () Alcohol () Tobacco () Coffee () Soft Drinks () Pain Reliever

Personal History

Pain in body

 Neck pain with difficulty swallowing Extreme neck stiffness with pain or Loss of feeling in inner thighs Leg pain that worsens with exercise shocks in arms or legs when Back pain with urinary problems
 but is relieved by resting moving neck

Types of pain

 Severe pain – interrupts sleep Constant pain that doesn't improve by changing positions or lying down

Current conditions

 Unable to balance when walking Loss of bowel or bladder control Recent major accident such as a fall Recent unexplained weight loss Blurred or double vision, dizziness from height, whiplash or blow to
 Recent progressive muscle weakness or faintness when neck is in certain the head shaking positions Memory loss after injury Recent or current fever over 102 Headaches Night sweats

Previously diagnosed conditions/medical history

 Congenital bone or joint condition Past history of cancer or currently Immune suppression as from
 Rheumatoid arthritis diagnosed with cancer chemotherapy, organ transplant, etc. Severe degenerative arthritis Diabetes 3 or more months use of steroid
 History of compression fractures Hepatitis medication or IV drugs (past or
 History of heart attacks Lupus recent) History of stroke Ankylosing spondylitis Osteoporosis or Osteopenia

Are you suffering from any of the symptoms below?

Skin: Rash Redness Itching Mole changes Nail changes Hair changes

Ear, Eyes, _____

Nose, Throat: Vision problems Ringing ears Hearing loss Nose bleeds Decreased smell Bleeding gums

Heart/Lungs: Cough Wheezing Shortness of Swollen hands Chest pain Palpitations
breath or feet

Digestion: Decreased Abnormal Vomiting Diarrhea Constipation Rectal bleeding

Urinary / Urgent Painful Frequent Bloody urine Abnormal Abnormal Impotence

Reproductive: urination urination urination vaginal menstruation

Endocrine: Heat/cold Tremors Excessive Fatigue
Intolerance thirst

Breast: Lumps Dimpling Discharge

Family History

 AutoImmune disorders Cancer Heart disease Mental Illness Stroke Arthritis Diabetes Kidney disease Seizure disorder Anemia

I hereby authorize the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, chiropractic care or any clinic services that he deems necessary in my case. The nature and purpose of the procedures, possible alternative and possibility of complications will be explained to me by the doctor. I acknowledge that no guarantee or assurance as to the results that may be obtained on the procedure will be give by the doctor. I furthermore authorize him to disclose all or any part of my patient record to any person or corporation, as required by law, or to my health insurance company or worker's compensation carrier in the processing of medical claims on my behalf. I acknowledge that any insurance I have is an agreement between the carrier and me and that I am responsible for any payment of any covered or non-covered services I receive.

Patient / Guardian signature _____

Date _____

Doctor's initials _____