

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: _____

PATIENT 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

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

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

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

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

(Already have a list? We can make a copy.) _____



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

Surgeries – Date, Type, and Reason: NONE

Major Injuries/Traumas: NONE _____

Major Hospitalizations: NONE _____

Patient No: _____



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?)



Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

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

Habits:

Cigarettes – (#/day) _____

Alcohol – (amount/day) _____

Coffee/Tea – (cups/day) _____

Rec. Drugs (List) _____

PEDIATRIC QUESTIONNAIRE

Name: (Last, First MI) _____

Today's Date: _____



PEDIATRIC REVIEW OF SYSTEMS

Pediatric:

- ADHD
- Allergies/Asthma
- Autism
- Back/Neck Pain
- Bed Wetting
- Behavioral issues
- Chronic Earaches
- Colic
- Constipation
- Growing Pains
- Nightmares
- Reflux
- None in this Category

Childhood Diseases:

- Chicken Pox: Age _____
- Measles: Age _____
- Meningitis: Age _____
- Mumps: Age _____
- Rubella: Age _____
- Tuberculosis: Age _____
- Whooping Cough: Age _____
- Other: _____ Age _____
- None in this Category

Has your child been vaccinated?

- No Yes

(Any Adverse Reactions? – Describe:) _____



INFANTS AND NEWBORNS

Prenatal History:

Location of Birth: Home Birthing Center Hospital

Birth Weight: _____ Birth Length: _____ Full Term? No Yes (Describe) _____

Complications during pregnancy? No Yes (Describe) _____

Medications during pregnancy or delivery? No Yes (List) _____

Cigarette / Alcohol / Drugs during pregnancy? No Yes (List) _____

Birth Interventions? No Yes Forceps Vacuum Caesarian Other: _____

Complications during delivery? No Yes (Describe) _____

Feeding History:

Breast fed? No Yes (How Long?) _____ Formula fed? No Yes (How Long?) _____ (Type?) _____

Introduced to cereal at _____ months old. Solids at _____ months old. Cow's milk at _____ months old.

Food / Juice allergies or intolerances? No Yes (Describe) _____

Developmental History:

Sleep (Hours per Night?) _____ Problems Sleeping? (Describe) _____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize: _____ (Doctor's Name) and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to: _____ (Minor Patient's Name)

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Date

Witness

Date

Patient No: _____