Case History

Medicare

Name ____ Date _______________

Street ____________________________ City ____________________ State ________ Zip _____________

Mailing Address (if different than street address): ____

H. Phone _____________________ W. Phone _____________________ Cell Phone: _____________________

E-mail address: _________________________________ Birth Date ____________ Age ________ Sex: M F

If female, is there a possibility that you might be pregnant? YES NO Marital Status: M S W D No. of children _____

Occupation ___________________________________ Employer _____________________________________

Spouse's Name __________________________ Spouse's Employer/Occupation __________________________

Who should we call in an emergency? Name _________________________________ Phone _______________

List any times you were hospitalized ____

____

List any surgeries (include date) ____

____

Previous Injuries: ____

____

Yes	No	Health Habits
☐	☐	Do you maintain a good posture?
☐	☐	Do you exercise regularly?
☐	☐	Do you eat 5 or more servings of fruits or vegetables each day?
☐	☐	Do you smoke?

Yes	No	
☐	☐	Do you drink 2 or more alcoholic beverages each day?
☐	☐	Do you take nutritional supplements?
☐	☐	Do you consider yourself to be healthy?
☐	☐	Do you frequently feel emotionally stressed?

In the following list, please check all of the conditions that you have experienced in the past year.

HEAD
- ☐ Headache
- ☐ Migraine
- ☐ Head feels heavy
- ☐ Vision problems
- ☐ Dizziness
- ☐ Hearing problems
- ☐ Ringing in ears

NECK
- ☐ Neck pain
- ☐ Grinding sounds in neck

SHOULDERS
- ☐ Pain in shoulders
- ☐ Can't raise arm

ARMS & HANDS
- ☐ Pain in arm
- ☐ Pain in hands
- ☐ Numbness or tingling in arm
- ☐ Numbness or tingling in hands
- ☐ Loss of strength in arms
- ☐ Loss of strength in hands

BACK
- ☐ Upper back pain
- ☐ Mid-back pain
- ☐ Rib pain
- ☐ Pain when breathing
- ☐ Low back pain

ABDOMEN - DIGESTION
- ☐ Nervous stomach
- ☐ Ulcers
- ☐ Constipation
- ☐ Heart burn
- ☐ Hiatal Hernia
- ☐ Nausea

HIPS, LEGS & FEET
- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Pain down upper leg
- ☐ Pain down below knee
- ☐ Pain in both legs
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Numbness or tingling in legs
- ☐ Numbness or tingling in toes
- ☐ Swollen ankles

WOMEN ONLY
- ☐ Menstrual pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Menopause
- ☐ Pre-menstrual Syndrome

MEN ONLY
- ☐ Urinary frequency
- ☐ Difficulty starting urination
- ☐ Night urination

GENERAL
- ☐ Nervousness
- ☐ Irritable
- ☐ Mood swings
- ☐ Depression
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Diabetes
- ☐ Cancer
- ☐ Breathing problems
- ☐ Asthma
- ☐ Allergies
- ☐ Sinus trouble
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Difficulty losing weight

Head, Neck, Arm or Hand Complaints

Describe Complaint:____

What does it feel like: Sharp Dull Burning Tingling Stabbing Numb Aching Weak

When did it start? __________________ What caused it or what were you doing? ________________________________

How often do you feel it? Is it Constant ☐ , **OR** _________ times per ☐ Day, ☐ Week, ☐ Month, or ☐ Year

What makes it worse? _____________________________ What makes it better? _______________________________

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint and a "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10

Is it worse in the: ☐ Morning ☐ Mid-day ☐ Evening ☐ Doesn't Matter. Did it occur ☐ Suddenly or ☐ Gradually?

Does anyone else in the family have this problem? ____

Notes: ____

Upper and Middle Back Complaints

Describe Complaint: ____

What does it feel like: Sharp Dull Burning Tingling Stabbing Numb Aching Weak

When did it start? __________________ What caused it or what were you doing? ________________________________

How often do you feel it? Is it Constant ☐ , **OR** _________ times per ☐ Day, ☐ Week, ☐ Month, or ☐ Year

What makes it worse? _____________________________ What makes it better? _______________________________

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint and a "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10

Is it worse in the: ☐ Morning ☐ Mid-day ☐ Evening ☐ Doesn't Matter Did it occur ☐ Suddenly or ☐ Gradually?

Does anyone else in the family have this problem? ____

Notes: ____

Lower Back, Hip and Leg Complaints

Describe Complaint: ____

What does it feel like: Sharp Dull Burning Tingling Stabbing Numb Aching Weak

When did it start? __________________ What caused it or what were you doing? ________________________________

How often do you feel it? Is it Constant ☐ , **OR** _________ times per ☐ Day, ☐ Week, ☐ Month, or ☐ Year

What makes it worse? _____________________________ What makes it better? _______________________________

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint and a "10" would be extreme discomfort.

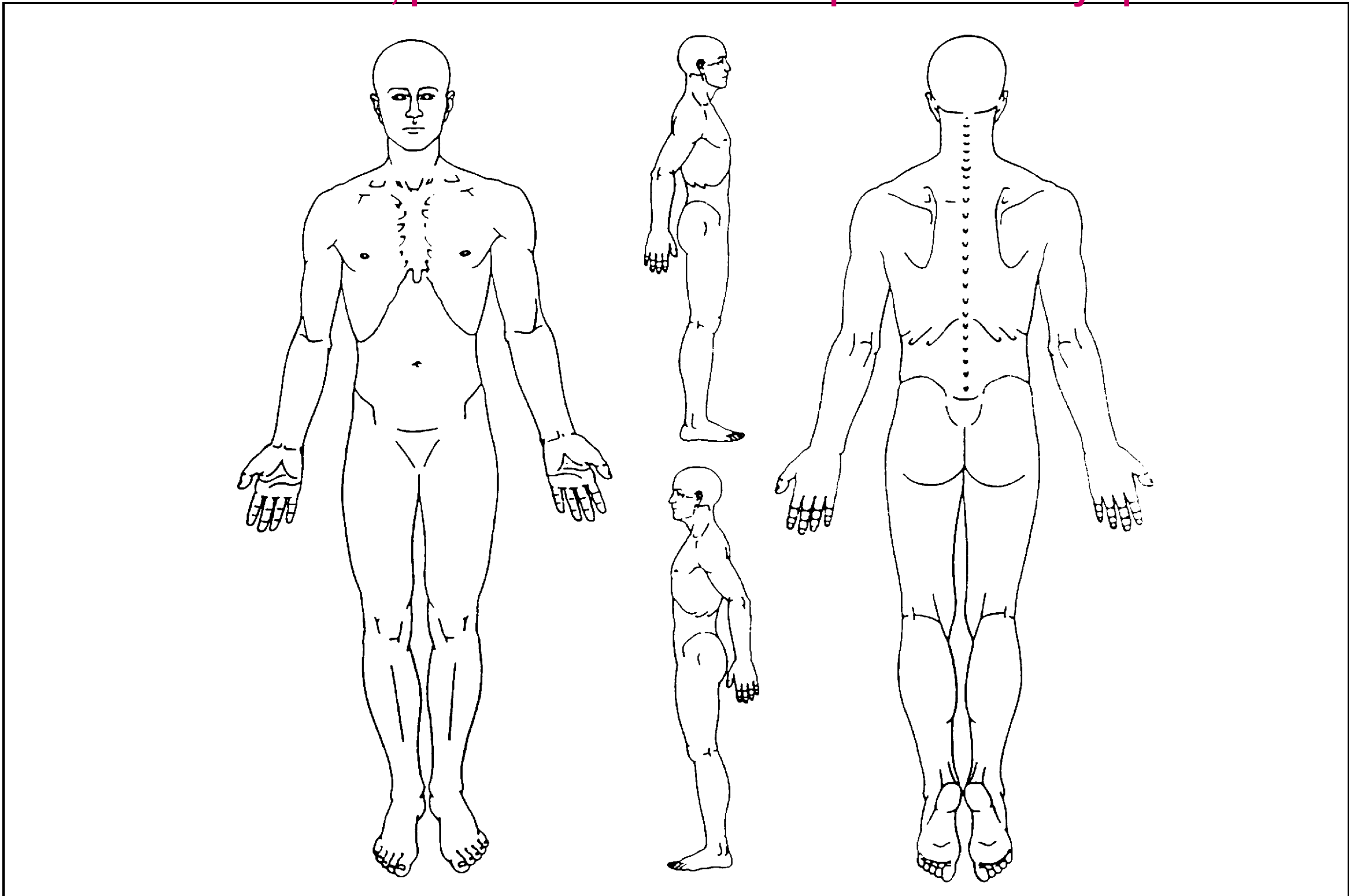
0	1	2	3	4	5	6	7	8	9	10

Is it worse in the: ☐ Morning ☐ Mid-day ☐ Evening ☐ Doesn't Matter Did it occur ☐ Suddenly or ☐ Gradually?

Does anyone else in the family have this problem? ____

Notes: ____

In the box below, please mark the areas of pain or other symptoms.



Check the following activities that you have had trouble performing since your complaints started and rate the difficulty.

	No Problem	Some Difficulty	Very Difficult	Can't Do
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Cooking	☐	☐	☐	☐
Fixing Hair	☐	☐	☐	☐

	No Problem	Some Difficulty	Very Difficult	Can't Do
Gardening/Yard Work . .	☐	☐	☐	☐
Sweeping/Mopping . . .	☐	☐	☐	☐
Sexual Activity	☐	☐	☐	☐
Employment	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Sports	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Hobbies/ Leisure Activities	☐	☐	☐	☐

Other Affected Activities

______________________________ ☐ Some Difficulty ☐ Very Difficult ☐ Can't Do

______________________________ ☐ Some Difficulty ☐ Very Difficult ☐ Can't Do

Have you ever received Chiropractic care? Y / N If yes where? ____

List other doctors consulted for present complaints:

Name __________________ When _________ Diagnosis____________________Treatment ______________________

Name __________________ When _________ Diagnosis____________________Treatment ______________________

Drugs you now take:____

____

Informed Consent: The role of a chiropractor is to help restore function to the spine through chiropractic adjustments. As this is done, most patients experience improvement in spine related conditions. The speed or extent of improvement is to a large degree dependent upon the inherent recuperative abilities of each patient. Some experience very rapid results, some slower results. A small percentage receive no outward benefit. Chiropractic does not treat pain, although most patients do experience reduced pain. Occasionally some patients experience a short-term increase in pain. We also do not diagnose and treat diseases other than those directly related to or caused by spinal misalignments. If you have other conditions that you wish evaluated, please consult with your medical doctor. As with any health care procedure, chiropractic adjustments have some risk. Increased risk often results from some underlying weakness or condition possessed by the patient that is not readily apparent through routine examination. Serious complications to chiropractic adjustments are considered by most authorities to be very rare, occurring once per one million adjustments. By individuals not properly trained, the risk can be much greater. When evaluating risks and benefits of health care procedures, you must consider the risk of not receiving care. Patients who choose medical care rather than chiropractic choose to accept the even greater risks associated with many medications and surgical procedures. Most chiropractic experts and patients agree that the benefits of chiropractic far outweigh the risks, however there are some risks. During the course of your care, you will be required to position yourself on the treatment tables and turn over on the tables. Although very rare, there have been occasions where patients have fallen off of a treatment table. By signing below you acknowledge that you understand the above risks and agree to continue with your care. You also acknowledge that you are capable of positioning yourself on the tables without assistance.

____

Patient's signature Date