

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (First MI Last) _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____
Email: _____ Gender: M / F Marital Status: Single / Married / Other
Social Security #: _____ Date of Birth: _____
Student Status: Full Student / Part Student / Non-Student Employed: Y / N
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline Preferred Language: English / Decline / Other: _____
Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline
*Referred By: (Name): _____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: (First MI Last) _____ 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

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

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: _____

RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - (Relationship) _____

Other than Self:

Name: (First MI Last) _____

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

Phone: _____ Email: _____

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

Patient No: _____

PEDIATRIC 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

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

Does anything make the complaint better? _____

Does anything make the complaint worse? _____

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
(Over-the-counter or Prescription.) _____

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

Surgeries – Date, Type, and Reason: NONE _____

Major Injuries/Traumas: NONE _____

Major Hospitalizations: NONE _____

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?) _____

Patient No: _____

Prenatal History: Home / Birthing Center / Hospital

Birth Weight: _____ **Birth Length:** _____

Interventions: NONE / Forceps / Vacuum / C-Section

Complications: NONE / _____

Medications during pregnancy: NONE / _____

Feeding and Development History:

Breast fed: No Yes - How long? _____

Formula: No Yes - What type? _____

Food allergies or intolerances? : No Yes

If yes, please describe: _____

Rolling over: No Yes

Sitting: No Yes

Crawling: No Yes

Walking: No Yes

Sleep: Hours/night _____ **Sleep well:** No Yes

Childhood diseases: None Chicken Pox Measles

Meningitis Mumps Whooping Cough Rubella

Other: _____

Has child been vaccinated? : No Yes

Any adverse reactions? : No Yes _____

Social and Occupational History:

Level of Education Completed: _____

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

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- Recent Weight Change
Fever
Fatigue
None in this Category

Musculoskeletal:

- Low Back Pain
Mid Back Pain
Neck Pain
Arm Problems
Leg Problems
Painful Joints
Stiff/Swollen Joints
Sore/Weak Muscles or Joints
Muscle Spasms/Cramps
Broken Bones
Other:
None in this Category

Neurological:

- Numbness or tingling sensations
Loss of Feeling
Dizziness or light headed
Frequent or Recurrent Headaches
Convulsions or seizures
Tremors
Stroke
Have you ever had a head injury?
Ever been in an auto accident?
Other:
None in this Category

Mind/Stress:

- Nervousness
Depression
Sleep Problems
Memory Loss or Confusion
Other:
None in this Category

Genitourinary:

- Sexual Difficulty
Kidney Stones
Burning/Painful Urination
Change in force/strain w Urination
Frequent Urination
Blood in Urine
Incontinence or Bed Wetting
Other:
None in this Category

Gastrointestinal:

- Loss of Appetite
Blood in Stool
Change in Bowel Movements
Painful Bowel Movements
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other:
None in this Category

Cardiovascular & Heart:

- Chest Pains
Rapid or Heartbeat changes
Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
Heart Problems
Other:
None in this Category

Respiratory:

- Difficulty Breathing
Persistent Cough
Coughing Blood
Asthma or Wheezing
Lung Problems
Other:
None in this Category

Eyes and Vision:

- Wear contacts/glasses
Blurred or double vision
Glaucoma
Eye disease or injury
Other:
None in this Category

Ears, Nose and Throat:

- Bleeding gums / mouth sores
Bad Breath or bad taste
Dental Problems
Swollen throat or voice change
Swollen glands in neck
Ringing in the ears
Ear - Ache/Ringing/Drainage
Sinus / Allergy problems
Nose Bleeds
Hearing Loss
Other:
None in this Category

Endocrine, Hematologic, and

Lymphatic:

- Thyroid problems
Diabetes
Excessive Thirst or urination
Cold Extremities
Heat or Cold intolerance
Change in hat or glove size
Dry skin
Glandular or hormone problem
Swollen Glands
Anemia
Easily Bruise or Bleed
Phlebitis
Transfusion
Immune system disorder
Other:
None in this Category

Skin and Breasts:

- Rash or Itching
Change in Skin Color
Change in hair or nails
Non-healing sores
Change of appearance of a mole
Breast Pain
Breast Lump
Breast Discharge
Other:
None in this Category

Women Only:

Are you pregnant?

- Yes - Due Date
No - Last Menstrual Period

- Infertility
Painful or Irregular periods
Vaginal Discharge
Other:
None in this Category

Pregnancies with Outcome & Date:

Comments:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature Date

Treating Doctor Signature Date

Patient No:

CONSENT FOR TREATMENT OF MINOR

Date _____

I hereby authorize:

and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

Minor Patient's Name

No.

Signature of Parent or Guardian

Date

Witness

Date

Remarks: _____
