

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_/\_\_\_/\_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact:  Text  Email  Home Phone  Other: \_\_\_\_\_

**\*Referred By:** (Name) \_\_\_\_\_

Family  Friend  Co-Worker  Doctor  Other: \_\_\_\_\_

**Race & Ethnicity:** (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaii or Other Pacific Islander
- White
- Decline

**Preferred Language:**

- English
- Spanish
- Other: \_\_\_\_\_
- Decline

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Relationship:

Child  Parent  Spouse  Other: \_\_\_\_\_

## FINANCIAL INFORMATION

Is today's visit the result of an accident?

No  Auto  Work  Other: \_\_\_\_\_

Will we be working with insurance?  No  Yes (Details)

Primary: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary: \_\_\_\_\_ ID#: \_\_\_\_\_

Where would you like statements sent?

Self  Other (Details below)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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

Account No: \_\_\_\_\_

# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: \_\_\_\_\_

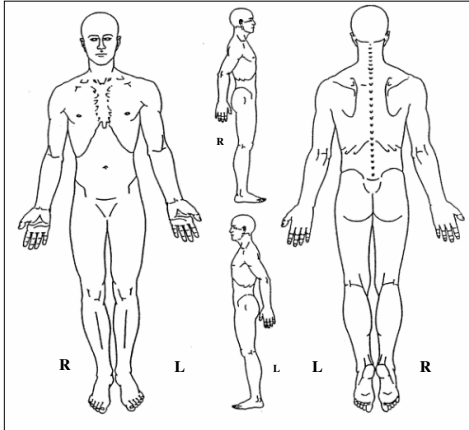
Secondary Complaints: \_\_\_\_\_

When did it start? \_\_\_/\_\_\_/\_\_\_ What happened? \_\_\_\_\_

Which daily activities are being affected by this condition? \_\_\_\_\_

## MAJOR COMPLAINT

### Location of Symptoms and Radiation



P\_\_ Pain  
N\_\_ Numb  
S\_\_ Spasm  
T\_\_ Tender  
H\_\_ Hypoesthesia

### Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

### Frequency:

- Off & On
- Constant

### Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: \_\_\_\_\_

### Does it radiate?

- No
- Yes (Please indicate on drawing)

### Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: \_\_\_\_\_
- Other: \_\_\_\_\_

### Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: \_\_\_\_\_

### Previous Treatment:

- None
- Chiropractor \_\_\_\_\_
- Medical Doctor \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- ER/Urgent Care \_\_\_\_\_
- Orthopedic \_\_\_\_\_
- Other: \_\_\_\_\_

### Previous Diagnostic Testing:

- None
- X-rays \_\_\_\_\_
- MRI \_\_\_\_\_
- CT \_\_\_\_\_
- Other: \_\_\_\_\_

### \*Women: Are you pregnant?

- No Last Menstrual Period: \_\_\_/\_\_\_/\_\_\_
- Yes Due date: \_\_\_/\_\_\_/\_\_\_

### Present Illness Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Prescription Medications & Supplements: None

Yes (List - Name, dosage, frequency) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Allergies to Medications: No known drug allergies

Yes (List - Name and reaction) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



