

Case History

Full Name: _____ Date of Birth: _____

History Of Present Injury/Illness List the complaints you are here to have treated, in order of importance & list how long you have had each:

- | | | | |
|----------|-----------------|----------|-----------------|
| 1. _____ | How long? _____ | 2. _____ | How long? _____ |
| 3. _____ | How long? _____ | 4. _____ | How long? _____ |
| 5. _____ | How long? _____ | 6. _____ | How long? _____ |

Please fill out the following for the primary condition for which you are here to be treated:

Circle the number that best matches your level of pain at its worst (0=no pain, 10=most severe) **0 1 2 3 4 5 6 7 8 9 10**

1. Is your condition related to an accident? Yes No If yes: Date of Accident _____ Auto Work Related Other
2. How did your pain or condition start? _____ When did it start? _____
3. What words **best describe** your present condition? (example: sharp, burn) _____
4. When is your condition **most** severe? _____ **least** severe? _____
5. What makes your condition feel **worse**? _____ feel **better**? _____
6. What activities are difficult because of your condition? _____
7. Have you seen any other health care provider for your present condition? Yes No If yes: who? _____
8. Personal habits: Tobacco Alcohol Vitamins Exercise Recreational drugs Medications & reasons _____
9. Family history related to present condition: _____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition.
Should x-rays be necessary; we would like to confirm that you are not pregnant at this time:

Female history: **Are you pregnant at this time?** Yes No Unsure but could be
Date of last menstrual cycle _____ Regular Irregular Using birth control pills Yes No

Are you experiencing or do you have any of the following: (check all that apply)

- | | | | |
|------------------------|--------------------------|-----------------------------|--------------------------|
| A sore that wont heal | Difficulty swallowing | Persistent cough/hoarseness | |
| Any bleeding/discharge | Lump/thickening anywhere | Wart/mole changes | |
| Bladder/bowel problems | Night pain | Weight loss without trying | None of the above |

Review of Systems

In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System (Check all that apply)

- | | | | | |
|-----------------------|-----------------|---------------------|-----------|--------------------------|
| Sensory changes | Facial drooping | Loss of balance | Seizure | Headache |
| Atrophy | Vision trouble | Memory loss | Dizziness | Anxiety |
| Joint deformity | Mood swings | Speech problems | Twitches | Limited range of motion |
| Psychiatric disorders | Joint locking | Muscle weakness | Stiffness | Depression |
| Difficulty walking | Joint swelling | Numbness | Tremors | Concussion |
| Lack of coordination | Popping noises | Extremity deformity | | None of the above |

Cardiovascular System (Check all that apply)

- | | | | | |
|-----------------------|------------------------|-----------------|----------------|--------------------------|
| Ankle swelling | Known vascular disease | Chest pain | Dizziness | Fainting |
| Mitral valve prolapse | Changes in skin color | Jaw pain | Phlebitis | Pin Stroke |
| Carotid blockage | Shortness of breath | Previous stroke | Varicose veins | Blood clots |
| | | Hypertension | | None of the above |

Past History List any surgeries you have had (including appendix, tonsils, wisdom teeth, etc)

- | | | | |
|----------|-------------|----------|-------------|
| 1. _____ | When? _____ | 2. _____ | When? _____ |
| 3. _____ | When? _____ | 4. _____ | When? _____ |

List any hospitalization other than surgeries, when & for what: _____

List any diagnosed conditions: (examples: diabetes, cancer, etc) : _____

List any current Doctors & conditions not previously listed: _____

List any major or minor falls or accidents & when occurred: _____

List any cracked or broken bones & when occurred: _____

Patient's Signature _____ Date _____

STAFF ONLY

ROS AND PFSH information reviewed with patient and agree with findings. _____