Dodge Center Chiropractic Office, P.A.

Chiropractic Case History/Patient Information

Date:__________________ Patient#___________ Age:_______ Birth Date:___________

Name:_________________________M.I______HomePhone:_______________Cell:__________________

Address:____________________________________City:___________________ State:______ Zip:___________

E-mail:____________________________ Contact preference: Home Work Cell or Email

Race:___________ Ethnicity:___________ Language:___________

Occupation/Employer:____Phone:_________________________

Marital: M S W D Spouse:___________________ Employer:_______________________________

Name of Nearest Relative:________________________ Address:_____________________Phone:___________

How were you referred to our office?____

Family Medical Doctor:____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?___________

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

__________ Vigorous Exercise | __________High Stress Activity
__________Moderate Exercise | __________Family Pressures
__________Alcohol Use | __________Financial Pressures
__________Drug Use | __________Other Mental Stresses
__________Tobacco Use | _________Other(specify) __________
__________Caffeine | ______________________________

HISTORY OF PRESENT ILLNESS:

Describe your current injury/ main health concern:

____

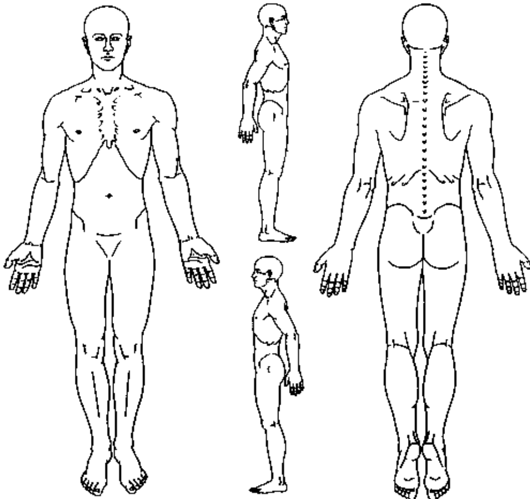
When did the problem begin? ____

How does it affect your daily living?

____

____

Please shade in your areas of concern.



Doctor Use Only:

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Please check all present symptoms relative to your *current condition*:

Head & Face

__ Base of skull __ Side/ temple __ Nausea/Vomiting __Ear pain
__ Throbbing __ Migraine __ Incapacitating __Ringing in ears
__ Front __ Head feels heavy __ Eyelids heavy __Double vision
__ Top __ Headache alters vision __ Pressure __ Nose bleeds
__ Eye Pain __ Jaw pain __ Flushing __Light sensitive
__ Blurry vision __Hearing loss __ Dizziness __Sinus problems
Pain is worse: __ In the morning, __During the day, __End of the day, __During sleep

Neck

__ Weakness __ Spasms __ Pain on motion __ Limited motion
__ Pain __ Swelling __ Lumps __ Throat tight
__ Stiffness __ Radiating pain __ Difficulty Swallowing
Pain is worse: __ In the morning, __During the day, __End of the day, __During sleep

Shoulder, Arm, & Hand

Shoulder:
__ Local pain __ Limited movement __ Pain on movement
__ Pain from neck __ Radiates down arm
Arm & Hand
__ Local pain __Pain on movement __ Swelling __ Cold hands
__ Radiates from neck __ Numbness/ Tingling __ Weakness __ Cannot raise
Pain is worse: __ In the morning, __During the day, __End of the day, __During sleep

Mid-back

__Weakness __ Pain __Spasms __Rib pain __ Chest pain
__ Stiffness __Swelling __Ltd. Motion __Pain on motion
Pain is worse: __ In the morning, __During the day, __End of the day, __During sleep

Low-back

__Weakness __ Pain __Spasms __Rib pain __ Chest pain
__ Stiffness __Swelling __Ltd. Motion __Pain on motion
Pain is worse: __ In the morning, __During the day, __End of the day, __During sleep

Hips, Legs, Knees, and Feet

__ Local pain __Radiating __From back __Down leg __Swelling
__Numbness __Tingling __Cramping __Spasms __Cold feet
__Varicose veins __Pain on motion __Weakness
Pain is worse: __ In the morning, __During the day, __End of the day, __During sleep

Nerves

__Burning __Numbness __Tingling __Tremor __Dizziness
__Lose balance __Coordination __Twitching __Difficulty with memory
__Loss of consciousness __Seizures __Generalized weakness

Sleep

__Good __Fair __Poor __Poor due to pain __Deep boring pain
__Difficulty falling/staying asleep __Wake often __ Fatigue

Have you ever suffered from or have been diagnosed as having:

__ Anemia __ Eating Disorder __ Ruptures/Hernias
__ Asthma __ Eczema __ Rheumatic Fever
__ Arthritis __ Epilepsy __ Thyroid disorder
__ Cancer __ Heart Disease __ Tuberculosis
__ Chicken Pox __ Hepatitis __ Vascular Disease
__ Depression __ Polio __ HIV Positive
__ Diabetes __ Psychological disorders __ Other___________

SYSTEMS REVIEW____

Please mark any of the following that you have experienced in the past 6 months.

Doctor Use Only:

Head, Ears, Eyes, Nose, and Throat

__ Vision problems __ Eye pain __ Hearing difficulty
__ Dental problems __ Headaches __ Ear ache/ infections
__ Sore throat __ Ringing in ears __ Sinus congestion
__ Bleeding gums/lips __ Nose bleeds __ poor night vision

Cardiovascular and Respiratory

__ Chest pain/tightness __ Low blood pressure __ Fainting
__ Shortness of breath __ Irregular/fast heartbeat __ Cold hands/feet
__ High blood pressure __ Dizziness __ Vericose veins
__ Light headed __ Swelling of legs/feet __ Coughing blood
__ Persistent Cough __ Lung problems __ Other ________

Gastrointestinal

__ Nausea __ Vomiting __ Heartburn
__ Gas/bloating __ Bloody stools __ Esophageal reflux
__ Constipation __ hemorrhoids __ Ulcers
__ Diarrhea __ Gall bladder problems __ Bowel incontinence
__ Abdominal Pain/Cramp

Genitourinary

__ Pain with Urination __ Loss of bladder control __ Frequent urination
__ Wake to Urinate __ Kidney Stones __ Blood in Urine
__ STD __ Sexual dysfunction __ Urgency with Urination

Male/Female Systems

__ Prostate problems __ Irregular periods __ Vaginal Pain/infection
__ Sexual dysfunction __ Menstrual Cramps __ Breast pain/ lumps
___# of pregnancies ___# of live births __ Menopause

Musculoskeletal

__ Joint pain __ Muscle pain __ Back stiffness
__ Joint stiffness __ Muscle stiffness __ Back pain
__ Joint swelling __ Difficulty w/limb movement

Nervous System

__ Nervousness/anxiety __ Seizures/convulsions __ Dizziness
__ Depression __ Forgetfulness __ Confusion
__ Paralysis __ Numbness/tingling __ Weakness

General

__ Weight loss __ Weight gain __ Night sweats
__ Excessive thirst __ Chills __ Fever
__ Insomnia __ Fatigue __ Bruise/bleed easily
__ Spots on fingernails __ Fragile/brittle nails __ Itching
__ Headaches __ Skin rash/sores __ Other__________

FAMILY HEALTH HISTORY (please check any that apply)

	Self	Mother	Father	Brothers	Sisters	Grandparents	None
Cancer							
Heart Disease							
Diabetes							
Asthma							
Eczema/Psoriasis							
Migraine Headache							
Seizure Disorder							
Stroke/TIA							
High Cholesterol							
Abnormal Bleeding							
High Blood Pressure							
Anemia							
Osteoporosis							
Alcohol /Drug Abuse							
Depression							
Other Psych. /Mental Illness							
Suicide (or attempted suicide)							
Genetic Disorder							

PAST HEALTH CARE HISTORY:

Have you had any previous chiropractic, medical, physical therapy, or osteopathy care? Yes/No

Please list where and when:____

Have you ever been hospitalized? Yes/No

If so, where and when? ____

Have you had any previous surgeries? Yes/No

____

____

Have you ever had any major illnesses, injuries, or falls? Yes/No

____

____

Are you taking any medications? Yes/No If yes, please complete the chart below.

Medication Name	Dosage (strength)	*Times Per Day*	How long have you been taking medication	*Who Prescribed this Medication?*

For Doctor's Use Only

Are there medications to which you have had an allergic reaction or unpleasant side-effects?
Yes/No If yes, name.

Listed medication allergies or reactions	***Reaction***

Are you currently taking any Vitamins or Supplements? Yes/No If yes, please list:

____

____

Upon signature of this document I am certifying that all the information provided is true, correct and complete. If more information about my illness becomes known I will tell the doctor when possible so that it can be added to my record. I also understand that I have read the separate informed consent sheet.

Patient Signature:____

Doctor Signature:____

Interpreter Signature:____________________________________

Parent or Guardian Signature:____________________________
(Please Sign, print your name, and relationship to the patient)