INTRODUCTION PATIENT CASE HISTORY

Patient No: _____ Date: _____

Name (Mr. Mrs. Miss Ms.)_____
(Last, First, MI)

Address: _____City _____State _____Zip _____

Home Phone: ( )_____Mobile: ( )_____Work Phone: ( )_____

Mobile Carrier: _____

Email Address: _____ Married _____Single _____ Other _____

Social Security No.: _____-_____-_____ Date of Birth: ____/____/____

Occupation: _____ Employer: _____

Name of your Insurance Company: _____

Primary Insurance Holder:_____ Primary Holders Date of Birth:_____

Previous Chiropractic Care? Yes No . Doctor's Name: _____

Major Complaint: _____Began When and How_____

Any Recent Surgeries_____ Any Recent Accident's_____

Medications_____ Allergies RX _____

Physicians Contact_____

Who (or what source) referred you? _____

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

Form 32/C

Tell Me About Your Health
At A Quick Glance

Name_____ Date_____

What is the **#1** thing that bothers you the most today? _____
When did it start?_____ (circle) Getting Better? Getting Worse? Staying the Same?
When **a Nerve is Pinched** – it can cause various sensations. Have you ever had this problem before? Yes No
When?_____
What **type** of sensation is yours? Sharp, Stabbing, Burning, Achy, Dull, Stiff & Sore, Hot, Throbbing, Numb
Is your nerve pressure sensation (circle) On & Off? Constant?
Does this sensation travel (**Radiate**) anywhere? No Yes Where? _____ Right? Left?
What, if anything, makes this sensation **better**? Heat, Ice, Rest, Stretching, OTC, Movement, Rx, Rubbing, Adjustments
What makes this sensation **worse**? Exercise, Sleeping, Sitting, Standing, Walking, Movement, Stretching, Lifting, Reaching
Misaligned vertebrae can cause nerve pressure, which over time, leads to discomfort. Rate your level of discomfort now:
None 0 1 2 3 4 5 6 7 8 9 10 Severe

Nerve Impulse Details

1) Subluxated vertebrae (bone out of place / pinched nerve) will cause irritation to **nerve** fibers. This decreases **signals** to organs and tissues, which lead to sickness, illness, symptoms, disease, and health problems.
Please describe all health concerns and conditions that you experience? _____
_____
2) Science tells us that our teeth are like our spine; they decay if not properly taken care of. When was the last time you brushed your teeth?_____ When was the last time you got adjusted? 10+ years/ 2-5 yrs/ only when I hurt/ 2x per month / never
3) Over time, spinal subluxations will cause arthritis and degeneration which cause a grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your neck & back? Yes No
4) If your spine is out of alignment for a long period of time, it can make you feel like you need to twist, stretch, tug, or crack your own neck or back. Do you often feel the need to crack or pop your neck or back? Yes No
5) Poor posture leads to poor health, loss of Nerve Health & signals. How would you rate your POSTURE?
Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent
6) Stress causes muscle stiffness that can cause your spine to misalign and accelerates spinal damage. Rate your STRESS level over the past 3 months.
None 0 1 2 3 4 5 6 7 8 9 10 Intense
7) The Standard American Diet is S.A.D. How would you rate the quality of your NUTRITIONAL intake?
Poor 0 1 2 3 4 5 6 7 8 9 10 High
8) When your body is well adjusted your energy level increases. How would you rate your ENERGY level in the past 30 days?
None 0 1 2 3 4 5 6 7 8 9 10 High
9) One of the 1st "side effects" of being adjusted is you will sleep better. How would you rate your SLEEP quality now?
Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent
10) A Sedentary Lifestyle (sitting) leads to an overloaded, toxic, subluxated body. How much exercise do you get weekly? _____
11) Do you think you are a healthy? Yes No Why? _____
12) There are 4 levels of Spinal Degeneration (decay). X-rays will tell us your level. Levels 1-3 are reversible, which means we have a window of opportunity to improve your health. Level 4 is too far advanced to reverse. What level do you think you MIGHT be? _____
How long do you think it will take to correct? _____
13) Medications may cause various side effects & hide the source of the actual health problem. They may also hinder the body's own ability to heal itself. It is our vision that someday your body will be healthy enough that you may eventually need fewer medications or none at all.
Do you share this vision with us? Yes No

14) Do you take a Multi-Vitamin? Yes No
15) Do you take a Mineral Supplement? Yes No
16) Do you take a Probiotic? Yes No
17) Do you take Flaxseed or Fish Oil? Yes No

18) What are YOUR top 3 health goals? 1)_____
2)_____
3)_____

CHIROPRACTIC!!! A LIFESTYLE, FOR A LIFETIME!!

HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Date:_____

Patient:_____ No.:_____

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

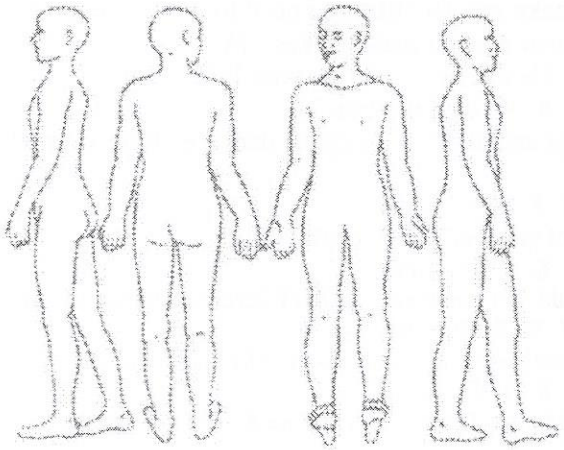
FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ YES ☐ NO

SYMPTOM LOCALIZATION



P ____ Pain T ____ Tender
N ____ Numb H ____ Hypoesthesia
S ____ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ _____

CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw Pain

Patient's Signature _____

●●●●●●●●●●●●●●●●●●●●●●DO NOT WRITE BELOW THIS LINE●●●●●●●●●●●●●●●●●●●●●●

_____

_____

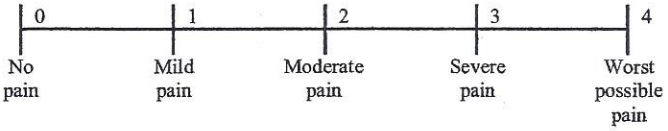
_____

Patient Accepted? ☐ Yes ☐ No Doctor's Signature_____

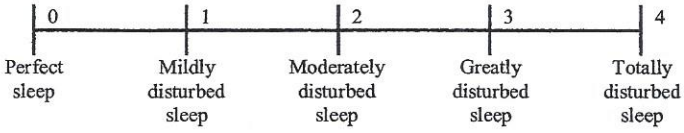
Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

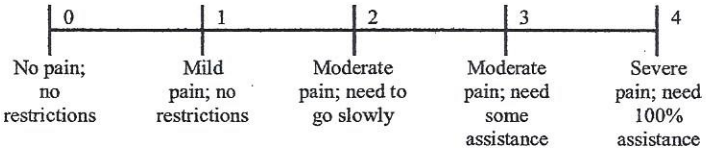
1. Pain Intensity



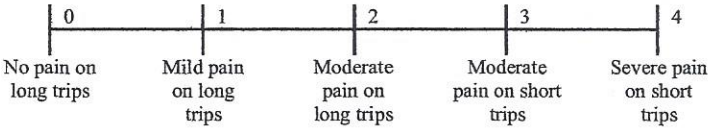
2. Sleeping



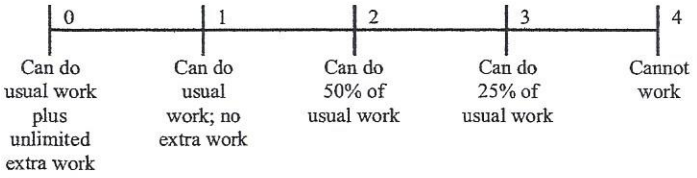
3. Personal Care (washing, dressing, etc.)



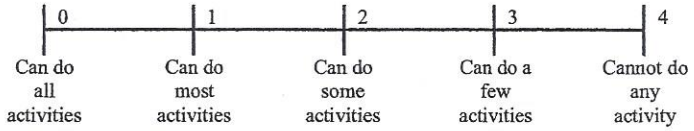
4. Travelling (driving, etc.)



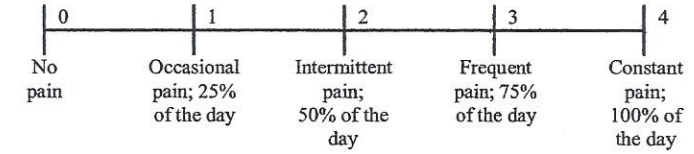
5. Work



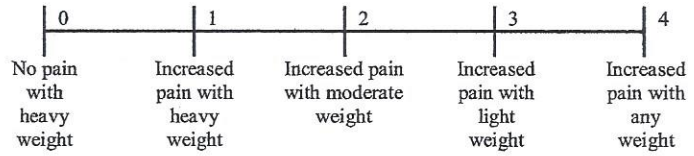
6. Recreation



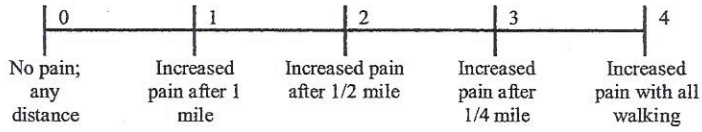
7. Frequency of Pain



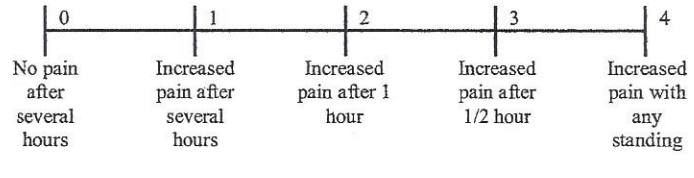
8. Lifting



9. Walking



10. Standing



_____ _____

Patient's Signature **Date**

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____