INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI)_____ **Preferred Name**: _____

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

Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #:_____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** _____

***Referred By:** _____

Ethnicity: Hispanic or Latino / Other **Preferred Language:** _____

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **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

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

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:** _____

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

Other than Self:
Full Name: _____ **Phone:** _____

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

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

Patient No: _____

PATIENT 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

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

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

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*_____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

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***

*(Already have a list? We can make a copy.)*_____

_____

_____

_____

_____

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?)*

_____

_____

_____

Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

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

_____

_____

_____

_____

Habits:

Cigarettes – *(#/day)* _____

Alcohol – *(amount/day)*_____

Coffee/Tea – *(cups/day)*_____

Rec. Drugs *(List)*_____

Patient No: _____

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: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have 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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

Godfrey Chiropractic
Release statements

Insurance Information:

I understand the following:

- Health and auto insurance policies are an agreement between an insurance carrier and me.
- This chiropractic office will prepare any necessary reports and forms to assist me in obtaining reimbursement from the insurance company.
- If the insurance company fails to make the expected payment, I understand that I am personally responsible for any unpaid charges.
- If I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

____ Initials

Consent for Professional Services and Release of Information

I hereby authorize and release the doctor and his/her designated assistant(s) to administer treatment, physical examination, x-ray studies, chiropractic care or any clinic services deemed necessary in my case.

I further authorize the doctor to release my patient records to any person or company who is financially liable for my care and to any other doctor who is involved in my care.

____ Initials

Privacy policy

I hereby certify that I was given the opportunity to review the privacy policy of this office.

____ Initials

Patient Signature: _____ Date: _____