PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Gender: Male - Female

Referred By:_____

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: _____

List **ALL Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain

☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure

☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain

☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's

☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: _____

List Type of **Medications** you are taking:

☐ Anxiety ☐ Muscle Relaxors ☐ Pain Killers ☐ Insulin ☐ Birth control ☐ Cardiovascular ☐ Allergy ☐ Seizure

☐ Other: _____

List your **Family History**:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition

☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio

☐ Prostate Problems ☐ Stroke/Heart Attack ☐ Please list all family members who had/has any of the problems above:

Example: Grandmother – High blood pressure

_____

_____

_____

Have you had any auto or other accidents? ☐ No ☐Yes

Describe: _____

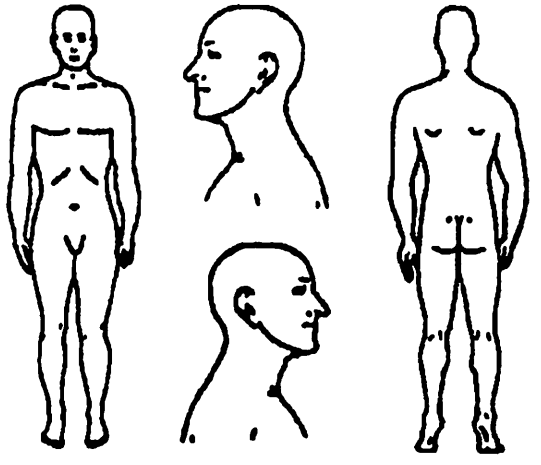
Date of last physical examination: _____ Do you smoke? ☐ No ☐Yes

Do you drink alcohol? ☐ No ☐Yes - how many per day? _____

Do you drink caffeine? ☐ No ☐Yes - how many per day? _____

Do you exercise? ☐ No ☐Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your SECOND complaint? _____Date problem began?_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your next complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Have you ever had chiropractic care? Yes □ No □

When? _____ Why? _____

Where? _____

When was your last adjustment? _____

Were X-rays taken? Yes □ No □

Primary Doctor

Doctor's Name:_____

Address:_____

_____

Phone: _____ Fax:_____

Date of Last Physical:_____

Do we have your permission to send your examination results to your doctor? □ Yes □ No

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? Yes □ No □

Date of Accident:_____

Do you have Health Insurance? Yes □ No □
If Yes, Name of Company: _____ Policy # _____

Are you covered by Medicare? Yes □ No □
If Yes, Health Insurance # _____

I will be paying today by Cash □ Check□ Credit Card □
MasterCard /Visa/ AMEX Card # _____ Exp. Date _____

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to Huml Integrative Health Care who accepts assignment of benefits. Should I receive payment directly from my insurance company for services rendered in the office, I will endorse checks to Huml Integrative Health Care. All accounts not paid within 90 days will automatically be put through on your credit card.

I provide permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, I indicate that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue service.

I have the right to discuss the treatment plan with my physician about the purpose, potential risks, and benefits of any tests ordered for me.

I recognize that the HIPAA forms were made available for me. I have read and understood the information provided in its entirety.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____

Medical Symptoms Questionnaire

Patient Name _____ **Date**_____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

Point Scale

0- *Never or almost never* have the symptoms
1- *Occasionally* have it, effect is *not severe*
2- *Ocasionally* have it, effect is *severe*
3- *Frequently* have it, effect is *not severe*
4- *Frequently* have it, effect is *severe*

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(does not include near- or far-sightedness Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeach
_____ Chest pain Total _____

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water Retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilites

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

GRAND TOTAL

NECK INDEX

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
⓪I have no pain at the moment.
①The pain is very mild at the moment.
②The pain comes and goes and is moderate.
③The pain is fairly severe at the moment.
④The pain is very severe at the moment.
⑤The pain is the worst imaginable at the moment.

Personal Care
⓪I can look after myself normally without causing extra pain.
①I can look after myself normally but it causes extra pain.
②It is painful to look after myself and I am slow and careful.
③I need some help but I manage most of my personal care.
④I need help every day in most aspects of self care.
⑤I do not get dressed, I wash with difficulty and stay in bed.

Sleeping
⓪I have no trouble sleeping.
①My sleep is slightly disturbed (less than 1 hour sleepless).
②My sleep is mildly disturbed (1-2 hours sleepless).
③My sleep is moderately disturbed (2-3 hours sleepless).
④My sleep is greatly disturbed (3-5 hours sleepless).
⑤My sleep is completely disturbed (5-7 hours sleepless).

Lifting
⓪I can lift heavy weights without extra pain.
①I can lift heavy weights but it causes extra pain.
②Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④I can only lift very light weights.
⑤I cannot lift or carry anything at all.

Reading
⓪I can read as much as I want with no neck pain.
①I can read as much as I want with slight neck pain.
②I can read as much as I want with moderate neck pain.
③I cannot read as much as I want because of moderate neck pain.
④I can hardly read at all because of severe neck pain.
⑤I cannot read at all because of neck pain.

Driving
⓪I can drive my car without any neck pain.
①I can drive my car as long as I want with slight neck pain.
②I can drive my car as long as I want with moderate neck pain.
③I cannot drive my car as long as I want because of moderate neck pain.
④I can hardly drive at all because of severe neck pain.
⑤I cannot drive my car at all because of neck pain.

Concentration
⓪I can concentrate fully when I want with no difficulty.
①I can concentrate fully when I want with slight difficulty.
②I have a fair degree of difficulty concentrating when I want.
③I have a lot of difficulty concentrating when I want.
④I have a great deal of difficulty concentrating when I want.
⑤I cannot concentrate at all.

Recreation
⓪I am able to engage in all my recreation activities without neck pain.
①I am able to engage in all my usual recreation activities with some neck pain.
②I am able to engage in most but not all my usual recreation activities because of neck pain.
③I am only able to engage in a few of my usual recreation activities because of neck pain.
④I can hardly do any recreation activities because of neck pain.
⑤I cannot do any recreation activities at all.

Work
⓪I can do as much work as I want.
①I can only do my usual work but no more.
②I can only do most of my usual work but no more.
③I cannot do my usual work.
④I can hardly do any work at all.
⑤I cannot do any work at all.

Headaches
⓪I have no headaches at all.
①I have slight headaches which come infrequently.
②I have moderate headaches which come infrequently.
③I have moderate headaches which come frequently.
④I have severe headaches which come frequently.
④I have headaches almost all the time.

BACK INDEX

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
⓪The pain comes and goes and is very mild.
①The pain is mild and does not vary much.
②The pain comes and goes and is moderate.
③The pain is moderate and does not vary much.
④The pain comes and goes and is very severe.
⑤The pain is very severe and does not vary much.

Personal Care
⓪I do not have to change my way of washing or dressing in order to avoid pain.
①I do not normally change my way of washing or dressing even though it causes some pain.
②Washing and dressing increases the pain but I manage not to change my way of doing it.
③Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④Because of the pain I am unable to do some washing and dressing without help.
⑤Because of the pain I am unable to do any washing and dressing without help.

Sleeping
⓪I get no pain in bed.
①I get pain in bed but it does not prevent me from sleeping well.
②Because of pain my normal sleep is reduced by less than 25%.
③Because of pain my normal sleep is reduced by less than 50%.
④Because of pain my normal sleep is reduced by less than 75%.
⑤Pain prevents me from sleeping at all.

Lifting
⓪I can lift heavy weights without extra pain.
①I can lift heavy weights but it causes extra pain.
②Pain prevents me from lifting heavy weights off the floor.
③Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤I can only lift very light weights.

Sitting
⓪I can sit in any chair as long as I like.
①I can only sit in my favorite chair as long as I like.
②Pain prevents me from sitting more than 1 hour.
③Pain prevents me from sitting more than 1/2 hour.
④Pain prevents me from sitting more than 10 minutes.
⑤I avoid sitting because it increases pain immediately.

Traveling
⓪I get no pain while traveling.
①I get some pain while traveling but none of my usual forms of travel make it worse.
②I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③I get extra pain while traveling which causes me to seek alternate forms of travel.
④Pain restricts all forms of travel except that done while lying down.
⑤Pain restricts all forms of travel.

Standing
⓪I can stand as long as I want without pain.
①I have some pain while standing but it does not increase with time.
②I cannot stand for longer than 1 hour without increasing pain.
③I cannot stand for longer than 1/2 hour without increasing pain.
④I cannot stand for longer than 10 minutes without increasing pain.
⑤I avoid standing because it increases pain immediately.

Social Life
⓪My social life is normal and gives me no extra pain.
①My social life is normal but increases the degree of pain.
②Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③Pain has restricted my social life and I do not go out very often.
④Pain has restricted my social life to my home.
⑤I have hardly any social life because of the pain.

Walking
⓪I have no pain while walking.
①I have some pain while walking but it doesn't increase with distance.
②I cannot walk more than 1 mile without increasing pain.
③I cannot walk more than 1/2 mile without increasing pain.
④I cannot walk more than 1/4 mile without increasing pain.
⑤I cannot walk at all without increasing pain.

Changing degree of pain
⓪My pain is rapidly getting better.
①My pain fluctuates but overall is definitely getting better.
②My pain seems to be getting better but improvement is slow.
③My pain is neither getting better or worse.
④My pain is gradually worsening.
⑤My pain is rapidly worsening.