Elite Chiropractic Health & Rehabilitation — Patient Case History

If you need any help while completing your paperwork, just ask. It is our goal to provide you the best service possible.
We want your visit here to be helpful, comfortable, and educational.

confidential health information

1. PATIENT INFORMATION

date

Last name	First name	M.I.	Sex ☐ Male ☐ Female

Date of Birth / Age	Social Security #	Occupation/ Employer

Address	City	State	Zip

Cell Phone ( )	Home Phone ( )	Work Phone ( )	Ext.

Email:	Spouse Name

IN CASE OF EMERGENCY,CONTACT	Name	Relationship
Phone ( )	Work Phone ( )	

Are you here because you were involved in a motor vehicle accident? ☐ yes ☐ no

Are you here because you were injured at your place of employment? ☐ yes ☐ no

Are you here because you were involved in another type of accident? ☐ yes ☐ no

Who is responsible for this account?

Will you be using health insurance to supplement payment to our office? ☐ yes ☐ no

2. HEALTH COMPLAINTS

What services interest you? (please mark all that apply)

☐injury prevention ☐treatment for pain ☐patient education classes

☐balance and coordination training ☐spinal and body alignment ☐posture correction

☐range of motion, mobility, and or flexibility ☐strengthing and stamina exercises ☐nutritional and supplement counseling

☐ other:______________________________

What is your **PRIMARY** complaint?

How long have you been experiencing your **PRIMARY** complaint?

How does the **PRIMARY** complaint feel? ☐dull/achy ☐numb ☐tingling ☐burning ☐cold ☐sharp

How often do you experience your **PRIMARY** complaint? ☐constantly ☐daily ☐weekly ☐monthly ☐yearly

Use the scale below to rate how your **PRIMARY** complaint affects your daily activities (please circle only one box)

1 no pain discomfort	2 slight discomfort	3 pain that does not affect my activity	4 pain that affects my daily activities	5 pain that prevents performing my daily activities	6 pain that limits my work schedule	7 pain that prevents working at all	8 pain that prevents work & all personal activities	9 pain that keeps me bed ridden	10 pain that causes thoughts of suicide

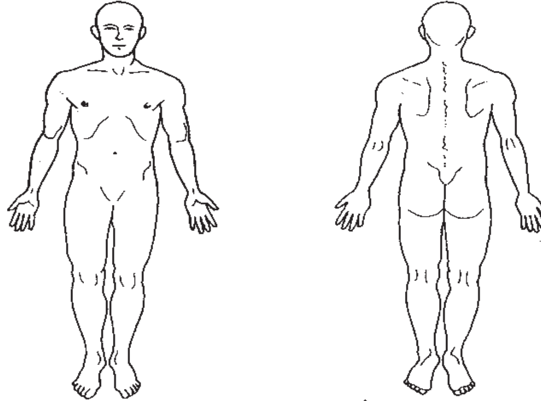
What do you believe is causing your **PRIMARY** complaint?

Please list other health complaints on the following lines.

1 ______________ 2 ______________ 3 ______________

Patient's Name

Please mark the areas of concern on the diagram to the right:
N = numbness
T = tingling
P = pain
W = weakness
B = Burning
A = Ache



3. LIFESTYLES & HABITS

Do you take a multi-vitamin? ☐ yes ☐ no	If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1		3	
2		4	

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1		3	
2		4	

Have you ever used tobacco? ☐ never ☐ daily ☐ weekly ☐monthly ☐ yearly

4. INJURIES

List any surgeries, broken bones, or dislocations you may have had.: ____________

Have you ever had a spinal tap or injection? ☐ yes ☐ no

Back Surgery ☐yes ☐no

List any other injuries caused by **slips**, **falls** or **impacts**. Begin with the most recent.

Type of injury	Type of treatment received	Date of injury
1		
2		
3		

Patient's Name

List any **job injuries** that you have experienced below. Begin with the most recent:		
Type of injury	Type of treatment received	Date of job injury
1		
2		
3		

Collision Description

☐ Single car crash	☐ Two vehicle crash	☐ More than 3 vehicles
☐ Rear end crash	☐ Side Impact crash	☐ Rollover
☐ Head-on crash	☐ Ran off Road	☐ Hit guard rail / tree

You were the:

☐ Driver	☐ Front Passenger	☐ Rear Passenger

Describe yourself during the crash

☐ You were unaware of the impending collision.

☐ You were aware of the impending crash and relaxed before the collision.

☐ You were aware of the impending crash and braced yourself.

☐ Your body, torso, and head were facing straight ahead.

☐ You had your head and/or torso turned at the time of collision

☐ Turned to left ☐ Turned to right

☐ You were wearing you seatbelt.

If yes, does your seatbelt have a shoulder harness? ☐Yes ☐ No

5. FAMILY HISTORY

Please circle the family member that has or had the following conditions.

diabetes	self	mother	father	sibling
heart problems	self	mother	father	sibling
kidney problems	self	mother	father	sibling
cancer	self	mother	father	sibling
headaches	self	mother	father	sibling
back pain	self	mother	father	sibling
obesity	self	mother	father	sibling
poor conditioning	self	mother	father	sibling

Patient's Name

6. SYSTEM REVIEW

Mark the following conditions that are currently a cause of significant concern for you.

General

☐ consistent fainting	☐ chills	☐ convulsions	☐ depression	☐ dizziness
☐ loss of weight	☐ fatigue	☐ fever	☐ headache	☐ loss of sleep
☐ weight gain	☐ double vision	☐ night sweats	☐ wheezing	☐ nervousness

Gastro-Intestinal

☐ constipation	☐ diarrhea	☐ gall bladder problems	☐ poor appetite	☐ jaundice
☐ liver problems	☐ nausea	☐stomach pain	☐ headache	☐ poor digestion
☐ rectal bleeding	☐ vomiting	☐ vomiting blood		

Eye/Ear/Nose/Throat

☐ asthma	☐ crossed eyes	☐ deafness	☐ earache	☐ ear discharge
☐ ear noises	☐ enlarged thyroid	☐ frequent colds	☐ hay fever	☐ hoarseness
☐ nasal obstruction	☐ nose bleeds	☐ pain in eyes	☐ poor vision	☐ sinusitis
☐ sore throat	☐ tonsillitis	☐ rapid eye movement		

Respiratory

☐ chest pain	☐ chronic cough	☐ difficulty breathing	☐ spitting blood	☐ spitting phlegm

Muscles/Joints/ Bones

☐ backache	☐ foot problems	☐ pain btwn. shoulders	☐ painful tailbone	☐ stiff neck
☐ spinal curvature	☐ swollen joints	☐ tremors	☐ twitching	☐ weakness

Cardio / Vascular

☐ ankle swelling	☐ high blood pressure	☐ low blood pressure	☐ heart trouble	☐ pain over heart
☐ poor circulation	☐ rapid heart	☐ slow heart	☐ stokes	

Skin or Allergies

☐ bruise easily	☐ dryness	☐ eczema	☐ hives	☐ itching
☐ sensitive skin				

Women

☐ cramps	☐ excessive flow	☐ hot flashes	☐ irregular cycle	☐ painful periods

We would like to thank the person/patient who referred you into our office. Please list their name(s) here. ____________________

I understand and agree to the following:

A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I'm requesting these services.

It is my responsibility to complete the clinic's form accurately.

It is my responsibility to notify the doctor if any of my information has changes or needs to be updated.

Original x-rays are the clinic's property and copies of the original films(s) and reports(s) will be released to me upon written request.

patient or guardian signature

date