

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_/\_\_\_/\_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact:  Text  Email  Home Phone  Other: \_\_\_\_\_

\*Referred By: (Name) \_\_\_\_\_

Family  Friend  Co-Worker  Doctor  Other: \_\_\_\_\_

Race & Ethnicity: (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaii or Other Pacific Islander
- White
- Decline

Preferred Language:

- English
- Spanish
- Other: \_\_\_\_\_
- Decline

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Relationship:

Child  Parent  Spouse  Other: \_\_\_\_\_

## FINANCIAL INFORMATION

Is today's visit the result of an accident?

No  Auto  Work  Other: \_\_\_\_\_

Will we be working with insurance?  No  Yes (Details)

Primary: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary: \_\_\_\_\_ ID#: \_\_\_\_\_

Where would you like statements sent?

Self  Other (Details below)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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

Account No: \_\_\_\_\_

# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: \_\_\_\_\_

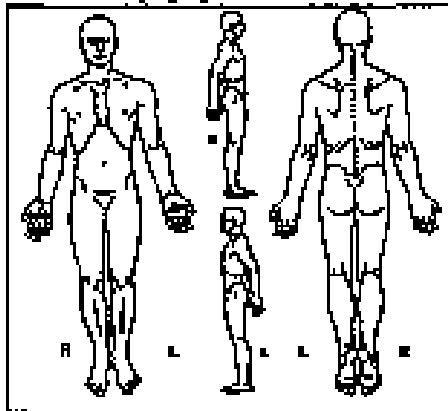
Secondary Complaint: \_\_\_\_\_

When did it start? \_\_\_\_/\_\_\_\_/\_\_\_\_ What happened? \_\_\_\_\_

Which daily activities are being affected by this condition? \_\_\_\_\_

## MAJOR COMPLAINT

### Location of Symptoms and Radiation



F \_\_\_ Pain                      T \_\_\_ Tender  
 N \_\_\_ Numb                    H \_\_\_ Hypoesthesia  
 S \_\_\_ Swell

### Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

### Frequency:

- Off & On
- Constant

### Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: \_\_\_\_\_

### Does it radiate?

- No
- Yes (Please indicate on drawing)

### Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: \_\_\_\_\_
- Other: \_\_\_\_\_

### Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: \_\_\_\_\_

### Previous Treatments:

- None
- Chiropractor \_\_\_\_\_
- Medical Doctor \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- ER/Urgent Care \_\_\_\_\_
- Orthopedic \_\_\_\_\_
- Other: \_\_\_\_\_

### Previous Diagnostic Testing:

- None
- X-rays \_\_\_\_\_
- MRI \_\_\_\_\_
- CT \_\_\_\_\_
- Other: \_\_\_\_\_

### \*Women: Are you pregnant?

- No      Last Menstrual Period: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Yes      Due date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Fracture/Dislocation Comments:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prescription Medications & Supplements:  None

Yes (List - Name, dosage, frequency) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies to Medications:  No known drug allergies

Yes (List - Name and reaction) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Today's Date: \_\_\_\_\_

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Accession No: \_\_\_\_\_

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# PAST, FAMILY, AND SOCIAL HISTORY

## PAST MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply and use comments to elaborate.)

### Illnesses:

- Asthma
- Autoimmune Disorder (type) \_\_\_\_\_
- Blood Clots
- Cancer (type) \_\_\_\_\_
- CVA/TIA (stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: \_\_\_\_\_

### Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: \_\_\_\_\_

### Hospitalizations: (Non-surgical with Date)

\_\_\_\_\_

\_\_\_\_\_

### Surgeries: (If yes, provide type & surgery date)

- Cancer
- Orthopedic
  - Shoulder - R / L \_\_\_\_\_
  - Elbow/Forearm - R / L \_\_\_\_\_
  - Wrist/Hand - R / L \_\_\_\_\_
  - Hip - R / L \_\_\_\_\_
  - Knee - R / L \_\_\_\_\_
  - Ankle/Foot - R / L \_\_\_\_\_
- Spinal Surgery
  - Neck: \_\_\_\_\_
  - Back: \_\_\_\_\_
- Other: \_\_\_\_\_

### Medical History Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- Unknown     Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

### Family History Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SOCIAL AND OCCUPATIONAL HISTORY

Marital Status:  Single  Married  Divorced  Other

Children:  None  1  2  3  4  Other: \_\_\_\_\_

Student Status:  Full Student  Part Student  Non-Student

Highest level of Education:  High School  College Grad.

Post Grad.  Other: \_\_\_\_\_

Employed:  No  Yes (Occupation) \_\_\_\_\_

Dominant Hand:  Right  Left  Ambidextrous

Smoking/Tobacco Use: If current smoker, amount = \_\_\_\_\_

- Every Day  Some Days  Former  Never

Alcohol Use:

- Every Day  Weekly  Occasionally  Never

### Caffeine Use:

- Coffee  Tea  Energy Drinks  Soda  Never

### Exercise frequency:

- Daily  3-4xs/week  2-3xs/week  Rarely  Never

Social History Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

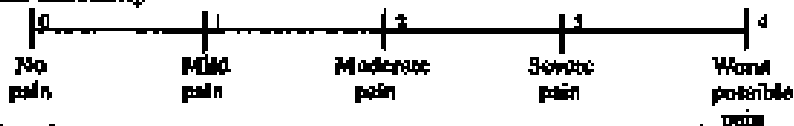


# Function Rating Index

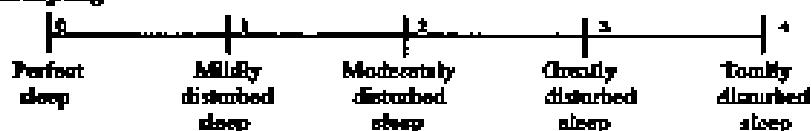
For use with NECK and/or BACK PROBLEMS ONLY.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage your everyday activities. For each item below, please **CIRCLE** the number which most closely describe your condition **RIGHT NOW**. Please mark with an "X" by the number which most closely describes your condition on a **NORMAL** daily basis.

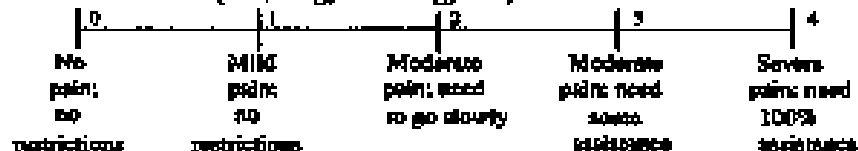
## 1. Pain Intensity



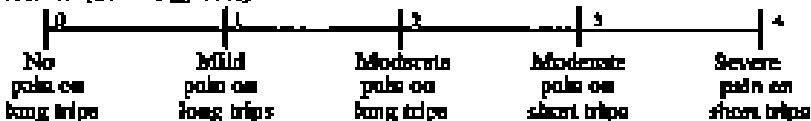
## 2. Sleeping



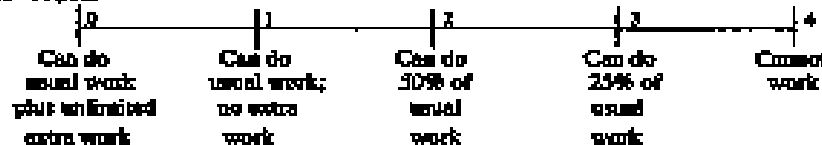
## 3. Personal Care (washing, dressing, etc.)



## 4. Travel (driving, etc.)



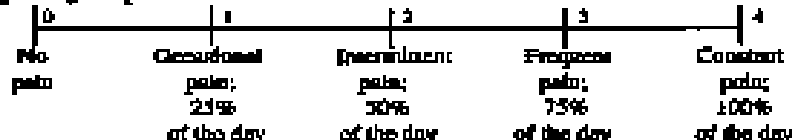
## 5. Work



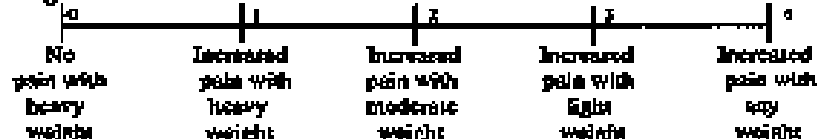
## 6. Recreation



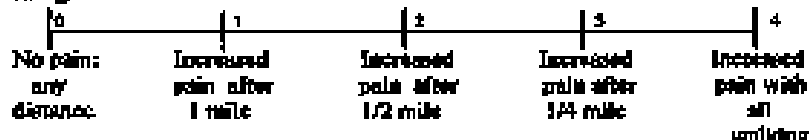
## 7. Frequency of pain



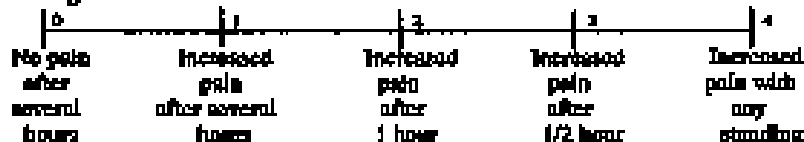
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_ ID#SS# \_\_\_\_\_ Plan ID \_\_\_\_\_ Total Score \_\_\_\_\_

PRINTED

Signature

Date

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Non-Covered Services Statement

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Eastern Oklahoma Chiropractic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Eastern Oklahoma Chiropractic the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay Eastern Oklahoma Chiropractic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refused to pay my claim. I authorize Eastern Oklahoma Chiropractic to ASSIGN ALL BENEFITS payable directly to Eastern Oklahoma Chiropractic, I understand that my financial arrangements are made directly with Eastern Oklahoma chiropractic and not with the insurance company, third party insurance, or attorney. I understand that medical liens will be filed at the Tulsa County Courthouse with my name on them. This is standard practice for all outstanding balances, auto accident cases, or workers compensation and an office policy of Eastern Oklahoma Chiropractic. It is my responsibility to pay for the courthouse lien fees as well as the lien release, unless I have made other arrangements with Eastern Oklahoma Chiropractic. I agree to give a copy of my insurance card to accurately file my insurance claims. I understand that if in the rare situation that any monies that have been overpaid to Eastern Oklahoma Chiropractic I would be granted a check of the difference upon request.

Acknowledgement of Receipt of Notice

I hereby acknowledge that I have access to a copy of the Notice of Privacy Practices (HIPPA).

Consent of Professional Services

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer the following:

1. The process of a physical examination and/or X-rays;
2. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms, etc.), often resulting in an audible pop or click sound;
3. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of vibration, electricity, traction, motion, and or nutritional advice;
4. That on occasion some temporary soreness and stiffness may occur; less frequently aggravation of the presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of Chiropractic Adjustment;
5. That the Chiropractor has made no guarantee of a positive outcome from treatment.

Additionally, I have been afforded ample opportunity for questions and answers.

Release of Information

I further authorize and release the doctor and whomever he/she may designate as his/her assistants to disclose all or any part of my record to any person or employer of the patient, including, and not limited to, hospital or medical service companies, insurance companies, representing attorney, workers compensation carriers, welfare funds or the patient employer.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Patient number: \_\_\_\_\_