Patient Case History

PATIENT CONTACT DATE: _____

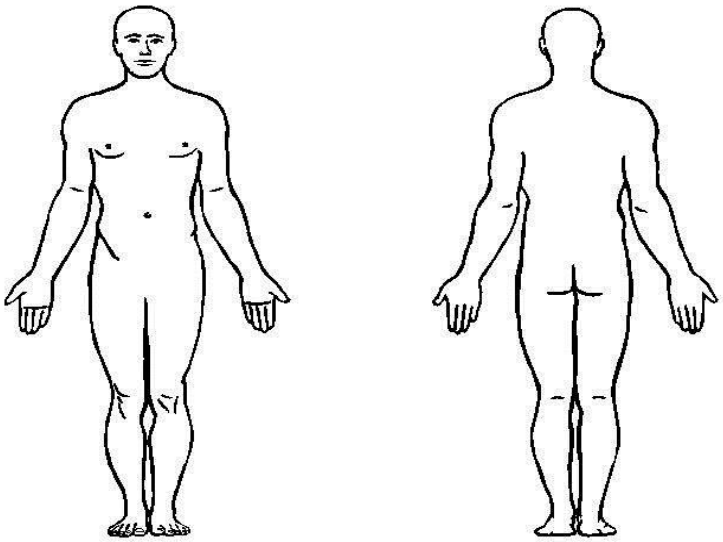
_____

Last Name First Name

1. What is your **primary** complaint? _____
2. **And is it the result of**: ☐ An accident or injury
   ☐ Work ☐ Auto ☐ Other _____
   ☐ A worsening long-term problem
   ☐ An interest in ☐ Wellness ☐ Other _____
3. **Onset** (When did you first notice your current Symptoms?) _____
4. **Intensity** (How extreme are your current symptoms?) Scale of 1-10, 1 being absent, 10 being agonizing: _____
5. **Duration and Timing** (When did it start / how often do you feel it?) ☐ Constant ☐ Comes and goes. How often? _____
6. **Quality of symptoms** (What does it feel like?)

☐ Numbness	☐ Dull	☐ Nagging	☐ Shooting	☐ Other: _____
☐ Tingling	☐ Aching	☐ Sharp	☐ Throbbing	_____
☐ Stiffness	☐ Cramps	☐ Burning	☐ Stabbing	_____

7. **Location** (Where does it hurt?)
   Circle the area(s) on the illustration



8. **Radiation** Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?
   _____
9. **Aggravating or relieving factors** What makes it better or worse, such as time of day, movements, certain activities, etc.
   _____
   What tends to worsen the problem? _____
   What tends to lessen the problem? _____
10. **Prior interventions** (What have you done to relieve the symptoms?_

☐ Prescription medication	☐ Physical therapy	☐ Chiropractic	☐ Heat
☐ Over the counter drugs	☐ Surgery	☐ Massage	☐ Other: _____
☐ Homeopathic remedies	☐ Acupuncture	☐ Ice	_____

11. **What else should Dr. Robotham know about your current condition?** _____
    _____
12. **How does your current condition interfere with your:**
    Work or career: _____
    Recreational activities: _____
    Household responsibilities: _____

13. Review of Systems:

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check beside any condition that you've **HAD** or currently **HAVE**.

Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck pain	☐	☐	Back problems	☐	☐	Hip Disorders
☐	☐	Knee injuries	☐	☐	Foot/ankle pain	☐	☐	Shoulder problems	☐	☐	Elbow/wrist pain	☐	☐	TMJ issues	☐	☐	Poor posture

Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins & needles	☐	☐	Numbness

Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High blood pressure	☐	☐	Low blood pressure	☐	☐	High cholesterol	☐	☐	Poor circulation	☐	☐	Angina	☐	☐	Excessive bruising

Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma	☐	☐	Shortness of breath	☐	☐	Emphysema	☐	☐	Hay fever	☐	☐	Apnea	☐	☐	Pneumonia

Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anorexia/bulimia	☐	☐	Ulcer	☐	☐	Food sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea

Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Blurred vision	☐	☐	Chronic ear infection	☐	☐	Hearing loss	☐	☐	Ringing in ears	☐	☐	Loss of smell	☐	☐	Loss of taste

Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Skin cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair loss	☐	☐	Rash

Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Thyroid issues	☐	☐	Immune disorders	☐	☐	Hypoglycemia	☐	☐	Frequent infection	☐	☐	Swollen glands	☐	☐	Low energy

Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Kidney stones	☐	☐	Erectile dysfunction	☐	☐	Bedwetting	☐	☐	Prostate issues	☐	☐	Infertility	☐	☐	PMS symptoms

Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Sudden weight loss	☐	☐	Fainting	☐	☐	Poor appetite	☐	☐	Fatigue	☐	☐	Weakness	☐	☐	Low libido
☐	☐	Sudden weight gain															

Past Personal and Social History

Please identify your past health history, including accidents, injuries and treatments. Please complete each section fully.

14. Illness: Check the illnesses that apply

Had	Have		Had	Have	
☐	☐	Rheumatoid Arthritis			
☐	☐	Polio			
☐	☐	Rheumatic fever			
☐	☐	Arteriosclerosis	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Chicken pox
☐	☐	Diabetes	☐	☐	Tuberculosis
☐	☐	Epilepsy	☐	☐	Ulcer
☐	☐	Goiter			
☐	☐	Gout	_____		
☐	☐	Heart disease	_____		
☐	☐	Hepatitis	_____		
☐	☐	HIV Positive	_____		
☐	☐	Measles/Mumps	_____		
☐	☐	Multiple Sclerosis	_____		

15. Operations – Surgical interventions, which may or may not have included hospitalization

☐ Bypass surgery
☐ Cosmetic surgery
☐ Elective surgery _____
_____
☐ Eye surgery
☐ Pacemaker / Defibrillator
☐ Spine_____
_____
_____
☐ Vasectomy
☐ Other:_____
_____
_____

16. . Injuries – Have you ever…

☐ Had a fractured or broken bone
☐ Had a spine or nerve disorder
☐ Been knocked unconscious

17. Are there any other hereditary health issues that you know of?_____

Social History

18: Tell Dr. Robotham about your health habits and stress levels.

Alcohol use	How much?_____	_____
Coffee use	How much?_____	_____
Tobacco use	How much?_____	_____
Pain relievers	How much?_____	_____
Soft drinks	How much?_____	_____
Water intake	How much?_____	_____

Prayer or meditation?	☐Yes	☐No
Job pressure / stress?	☐Yes	☐No
Financial peace?	☐Yes	☐No
Vaccinated?	☐Yes	☐No
Mercury fillings?	☐Yes	☐No
Recreational drugs?	☐Yes	☐No

20. Activities of Daily Living

	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐
Rising out of chair	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Lying down	☐	☐	☐
Bending over	☐	☐	☐
Climbing stairs	☐	☐	☐
Using a computer	☐	☐	☐
Getting in/out of car	☐	☐	☐
Driving a car	☐	☐	☐
Looking over shoulder	☐	☐	☐
Caring for family	☐	☐	☐

	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐
Household chores	☐	☐	☐
Lifting objects	☐	☐	☐
Reaching overhead	☐	☐	☐
Showering / bathing	☐	☐	☐
Dressing myself	☐	☐	☐
Love life	☐	☐	☐
Getting to sleep	☐	☐	☐
Staying asleep	☐	☐	☐
Concentrating	☐	☐	☐
Exercising	☐	☐	☐
Yard work	☐	☐	☐

21. What is the major stressor in your life? _____

22. How much sleep do you average per night? _____ hours.

23. What is the approximate age of your mattress and pillow? _____

24. Preferred sleeping position? _____

25. Describe your typical eating habits ☐Skip breakfast ☐Two meals a day ☐Three meals a day ☐Snacking between meals

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest time, please read each statement and initial your agreement.

Initial

_____ **I instruct the chiropractor to deliver the care that, in her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

_____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

_____ **I grant permission to be called to confirm or rescheduled an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

_____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services in this office.**

_____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

_____ **I understand and agree to pay a $50.00 charge for all missed 'no show' appointments not previously cancelled & agree all payments are paid in-full at time of service.**

If the patient is a minor child, print the child's full name: _____

_____ _____

Signature Date (MM/DD/YY)