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: __________

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PATIENT INTAKE FORM

Patient's Name: ____ Date: ____________________________

1. Is today's problem caused by _____ Auto Accident _____Workman's Compensation
2. How often do you experience your symptoms?
   ____constantly (76-100% of the time) ____occasionally (26-50% of the time)
   ____frequently (51-75 % of the time) ____intermittently (1-25% of the time)
3. How are your symptoms changing with time?
   ____getting worse ____staying the same ____getting better
4. How much has the problem interfered with your work?
   ____not at all ____a little bit ____moderately ____quite of bit ____extremely
5. How much has the problem interfered with your social activities?
   ____not at all ____a little bit ____moderately ____quite of bit ____extremely
6. Who else have you seen for your problem?
   ____chiropractor ____massage therapist ____orthopedist ____ER Physician ____Neurologist
   ____Physical Therapist ____Primary Care Physician ____Other: ________________________
7. How long how you had this problem? __________
8. How do you think your problem began? ____
9. Do you consider this problem to be severe? ____Yes ____Yes, at times ____No
10. What aggravates your problems? ____
11. What alleviates your pain? ____
12. What concerns you most about your problem? ______________________________________
13. What does it prevent you from doing? ____
14. What is your: Height _______Weight ______ Date of birth ___________
15. Occupation: ____Trader ____Laborer ____Professional/Executive ____Homemaker ____student
    ____white collar ____truck driver ____retired ____unemployed ____other ______________________
16. What type of exercise do you do? ____strenuous ____moderate ____light ____none
17. Indicate if you have any immediate family members w/any of the following. (M)other, (F)ather or (S)ibing
    ____Rheumatoid Arthritis ____Diabetes ____Lupus ____Heart Problems ____Cancer ____ALS
18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present column".

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:______________________				

19. How would you rate your overall health?
__Excellent __Very Good __Good __Fair __Poor

20. Are you allergic to any medications? ____Yes ____No
If yes, what is the reaction? ____________________

21. Please list all prescription medications you are currently taking.
____
____

22. Please list all over-the-counter medications or supplements you are currently taking.
____
____

23. Please list all surgical procedures you have had.
____
____

24. What activities do you do at work?
Sit: ____ most of the day ____half of the day ____a little of the day
Stand: ____ most of the day ____half of the day ____a little of the day
Computer work: ____ most of the day ____half of the day ____a little of the day
On the phone: ____ most of the day ____half of the day ____a little of the day
Drives: ____ most of the day ____half of the day ____a little of the day
____performs manual labor most of the day ____reads about half of the day ____travels frequently a little of the day ____None

25. What activities to you do outside of work?
____Aerobics ____skiing ____basketball ____soccer ____baseball ____softball ____bicycling ____swimming
____football ____tennis ____golf ____triathlons ____hiking ____volleyball ____ice hockey ____walking
____inline skating ____weight lifting ____jogging ____working out ____marital arts ____yoga ____rock climbing
____other ____________________

26. Have you ever been hospitalized? ____Yes ____No _____ Previously mentioned
If yes, why?
____

27. Have you ever been to a chiropractor before? ____Yes ____No. If yes, how long ago? ____________
Results: ____great ____good ____fair ____poor

28. Have you had any significant trauma? ____Yes ____No. If yes, what kind? ____________

29. Anything else pertinent to your visit today? ____________________

Patient or Patient's guardian signature: ____________________ Date: ____________

Vehicle Accident Information

Patient's name: ______________________________ **Date:**______________________

1. Date of accident: ______________ Time of Accident: _____________ am or pm
2. Please describe the accident in your own words:

____

____

3. How many vehicles were involved in the accident? _______
4. How many people were in the accident vehicle? ________
5. What was the estimated damage to the vehicle you were in? _____________
6. Where were you sitting in the vehicle during the accident?
   ___driver ____ front passenger ____rear passenger ____pedestrian
7. What state did the accident occur? ____________ What city did the accident occur? ____________
8. What street or nearest intersection were you on when the accident occurred? _______________
9. What direction were you traveling in? ____N ____W ____S ____E ____NW___NE____SW____SE
10. What was your speed? ____________________
11. Choose the primary type of impact ____front ____rear ____left _____right or other? _________
12. What were the driving conditions? ____dry ____wet ____icy or other? _______
13. Did your vehicle hit anything after the accident? ____hit a guardrail ____hit a tree ____rolled over
    ____was run off the road ______________other or ____NA
14. Did you know the accident was about to happen? ____aware ____aware, but relaxed before impact
    ____aware of impending collision and braced
15. What type of vehicle were in you in? Make____________ model_________________
16. What type of vehicle impacted yours? Make____________ model_________________
17. At the time of the impact were you ____slowing down ____stopped ____gaining speed or ____traveling at a steady speed?
18. At the time of the impact was the other vehicle ____slowing down _____stopped _____gaining speed or _____traveling at a steady speed?
19. During and after the crash what happened to your vehicle? Check all that apply.
    ____kept going straight ____kept going straight hitting car in front ____ was hit by another vehicle
    ____spun around ____spun around & hit a stationary object ____hit a stationary object
20. Did you lose consciousness during the accident? Yes or No. Please describe how you felt immediately after the crash. ____
21. How was your head position during the accident?
    ____head facing forward ____head turned left ____head turned right ____head facing upward
    ____head facing downward ____head facing to the right and & upward
    ____head facing to the right and downward ____head facing to the left & upward
    ____head facing to the left & downward
22. How was your torso positioned during the accident?
    ____forward ____to the left ____to the right ____extended ____flexed ____flexed w/right rotation
    ____ extended w/right rotation ____flexed w/ left rotation ____extended w/left rotation
23. How were your hands positioned during the accident?
    ____left hand on the steering wheel ____right hand on the steering wheel ____both hands on steering wheel
    ____left hand on dashboard ____right hand on dashboard ____both hands on the dashboard
    ____hand(s) on the seat in front ____hand(s) resting alongside ____hand(s) on ceiling of car
24. Was your foot on the brake? ____Yes ____No or ____N/A. If yes, which foot was on the brake? Right or Left?
25. Did your head hit any of the following?
    ____windshield ____steering wheel ____side door ____dashboard ____car frame ____ another passenger
    ____ seat ____side window ____N/A

26. Did your face hit any of the following?
____windshield ____steering wheel ____side door ____dashboard ____car frame ____ another passenger
____ seat ____side window ____N/A
27. Did your shoulder hit any of the following?
____windshield ____steering wheel ____side door ____dashboard ____car frame ____ another passenger
____ seat ____side window ____N/A
28. Did your neck hit any of the following?
____windshield ____steering wheel ____side door ____dashboard ____car frame ____ another passenger
____ seat ____side window ____N/A
29. Did your chest hit any of the following?
____windshield ____steering wheel ____side door ____dashboard ____car frame ____ another passenger
____ seat ____side window ____N/A
30. Did your hips hit any of the following?
____windshield ____steering wheel ____side door ____dashboard ____car frame ____ another passenger
____ seat ____side window ____N/A
31. Did your knees hit any of the following?
____windshield ____steering wheel ____side door ____dashboard ____car frame ____ another passenger
____ seat ____side window ____N/A
32. Did your feet hit any of the following?
____windshield ____steering wheel ____side door ____dashboard ____car frame ____ another passenger
____ seat ____side window ____N/A
33. What kind of headrest was in your vehicle?
____moveable fixed headrest ____non-movable fixed headrest ____no headrest
34. Where was the headrest positioned on your head?
____top of back of head ____middle height of the back of the neck ____lower portion of back of head
____at the level of the back of the neck ____at the level of shoulders ____N/A
35. Did you have your seatbelt on during the accident? ____Yes ____No ____Cannot remember if had seatbelt on
If yes, ____shoulder ____lap ____both lap and shoulder ____baby car seat _____booster seat
36. Did you slide out of your seat belt during the accident? ____Yes ____No.
If yes, ____slid out completely ____partially slid out
37. What was damage in your vehicle? Check all that apply.
____windshield ____steering wheel ____dashboard ____seat frame ____side window ____rear window
____rear bumper ____front bumper ____trunk ____front left door ____front right door ____back left door
____back right door ____mirror ____knee bolster ____completely totaled
38. Choose items that dented inward? ____floorboards ____side door ____dashboard _____N/A
39. Choose the doors that would not open as result of the accident?
____front left ____front right ____rear left ____rear right ____N/A
40. Did the Police come the accident site? ____Yes ____No
41. Were there any witnesses? ____Yes ____No
42. Was a police report filed? ____Yes ____No
43. Was a traffic violation issued? ____Yes ____No. If yes, to whom? ____________________
44. Did you go to the hospital? ____Yes ____No. If no, why and do not answer 44-53 ____________________
45. When did you go to the hospital? ____immediately ____Next day ____2 days or more after the accident
46. How did you get to the hospital? ____ambulance ____private transportation
47. Name of the hospital? ____________________
48. Were you hospitalized overnight? ____Yes ____No
49. Check what you were prescribed at the hospital.
____pain medication ____muscle relaxers ____neck brace or ____other. ____________________
50. Did you receive any stitches for any cuts at the hospital? ____Yes ____No
51. Were x-rays taken at the hospital? If yes, which area(s) were taken? ____________________
52. Was an MRI taken at the hospital? If yes, which area(s) were taken? ____________________
53. Was a CT scan taken at the hospital? If yes, which area(s) were taken? ____________________
54. Have you been able to work since the accident? ____Yes ____No. How many workdays have you missed? _____

55. Prior to the accident were you able to work on equal basis with others your age? ____Yes ____No
56. Have you had any of the following symptoms since your accident? Please check all that apply.
    ____arm/shoulder pain ____back pain ____back stiffness ____chest pain ____dizziness ____ear buzzing
    ____ear ringing ____fatigue ____feet/toe numbness ____hand/finger numbness ____headaches
    ____irritability ____jaw problems ____leg pain ____memory loss ____nausea ____neck pain ____neck stiffness
    ____shortness of breath ____sleep difficulty ____stomach upset ____tension ____vision blurred
57. Is this condition getting progressively worse? ____Yes ____No ____Unknown
58. How often do you have this pain? ____________________
59. Is it constant or does it come and go? ____________________
60. Does it interfere with your: ____work ____sleep ____daily routine ____recreation
61. Activities or movements that are painful to perform:
    ____sitting ____standing ____walking ____bending ____lying down

I certify that the above information is correct to the best of my knowledge.

Patient or Patient's guardian signature: ______________________________ Date: ____________________

Care Chiropractic & Acupuncture Clinic
1503 Graham Avenue
Henderson, NC 27536
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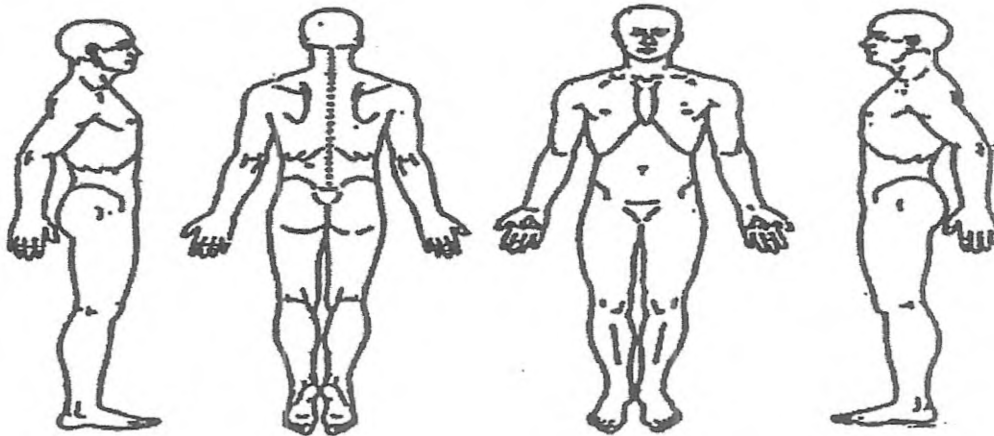
A: Identify your areas of discomfort by marking the affected body parts in the illustration in order of complaint with a number. i.e.: 1 lower back; 2 neck; 3 shoulder; etc.

B: Indicate the area name along with your specific symptoms associated with each selected area.

C: Rate your discomfort associated with each selected with 1 (least pain) to 10 (worst pain).



	Sharp	Dull	Diffuse	Achy	Burning	Shooting	Stiff	Numb	Tingly	Sharp w/motion	Shooting w/motion	Stabbing w/motion	Electric like w/motion	other
Example														
L R Lower back	X			X			X							

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	(X) 7	8	9	10

1.

L R														

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10

2.

L R														

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10

3.

L R														

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10

4.

L R														

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10