Cole Chiropractic Case History

Name_____ Sex __M __F Marital Status: S M D (other)
DATE:_____
Referred by_____

Have you ever received Chiropractic Care? Yes No If yes, when and whom?
1. Primary reasons for seeking chiropractic care today:
Primary Condition or complaint:
_____
_____
Condition 2:
Condition 3:
Condition 4:
The above condition(s) are due to Auto Accident: YES NO or Work Related Injury YES NO
Condition(s) began when and how?
_____
Please circle the Quality of the complaints/pain: dull aching sharp shooting burning throbbing deep nagging other _____
Does this conditions/pain radiate or travel (shoot) to any areas of your body? YES NO Where?
Do you have any numbness or tingling in your body? YES NO Where?
Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)
How frequent are condition(s) present, how long does it last?
_____
Does anything aggravate the condition(s)? YES NO
Does anything make the condition(s) better? YES NO

2. Previous interventions, treatments, medications, surgery, or care you've sought for your condition(s):
_____
_____

3. Past Health History:

A. Previous illnesses you've had in your life:
_____
_____
_____

B. Previous injury or trauma:
_____
_____
_____

Have you ever broken any bones? Which?
_____

C. Allergies (what are you allergic to?):

D. Medications (what medications are you currently taking?):

_____
_____
_____

Surgeries:
Date, Type of Surgery
_____
_____
_____
_____
_____
_____

D. Females/ Pregnancies and outcomes:
Pregnancies/Date of Delivery Outcome
_____
_____
_____
_____
What was the date of the beginning of your last menstrual period?
_____

Are you Pregnant Now? YES NO

1. Family Health History:
Associated health problems of relatives *(circle)*: Cancer Heart Diabetes Other
Deaths or Health Problems in immediate family:
Mother Cancer Heart Diabetes Other
Father Cancer Heart Diabetes Other
Sibling Cancer Heart Diabetes Other

2. Social and Occupational History:

A. Level of Education: O high school O some college O college graduate O post graduate studies
B. Job description:
_____
C. Work schedule:
_____
D. Recreational activities:
_____
E. Lifestyle *(circle)*:

How often do you exercise? Daily Weekly Sometimes Never
How often do you drink alcohol? Daily Weekly Sometimes Never
How often do you smoke? Daily Weekly Sometimes Never
Do you use recreational drugs? Yes No
How is your diet? Healthy Healthy Sometimes Fast Food
_____
_____
Do you have Insurance? YES NO Insurance Carriers Name:

Comprehensive Medical History

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____
Date _____
Doctors Signature _____

Date _____

REVIEW OF SYSTEMS

GENERAL APPEARANCE
□ Weight Loss □ Weight Gain □ Change in Sleeping Patterns □ Change in Activity Capacity
NEUROLOGICAL
□ Anxiety □ Headaches □ Depression □ Meningitis □ Paralysis □ Seizure □ St roke □ Tingling □Tremors □ Memory Loss □ Fainting spells □ Dizziness □ Head injuries □ Blackouts or near blackouts □ Change in sensation anywhere on your body □ Localized weakness or numbness
EARS, EYES, NOSE, & THROAT
□ Hay fever □ Glaucoma □ Polyps □ Allergy □ Cataracts □ Goiter □ Hoarseness □ Double vision □ Gum problems □ Eye problems □ Ear Infections □ Glasses/contacts □ Hearing Loss □ Ear discharge/pain □ Frequent nosebleeds □ Ringing in your ears □ Sinus infect ions □ Swollen glands
CARDIOVASCULAR
□ Angina □ Leg cramps □ Ankle swelling □ Awakening at night short of breath & getting out of bed □ Cardiac catheterization □ Cold hands or feet □ Congenital heart defects □ Dizziness when standing up quickly □ Heart at tacks □ Heart failure □ High or low blood pressure □ Irregular heart rate □ Purple fingers or lips □ Leg pain that resolves with rest □ Heart palpitations □ Varicose veins □ Chest pains □ Murmurs
RESPIRATORY
□ Asthma □ Breathlessness when lying flat □ Prolonged cough □ Coughing up blood □ Emphysema □ Shortness of breath □ Tuberculosis □ Pneumonia □ Frequent infections (bronchitis) □ Wheezing □ Pleurisy
SKIN
□ Abscess □ Dandruff □ Acne □ Oily skin □ Boils □ Rashes □ Hives □ Dry skin □ Lumps □ Psoriasis □ Jaundice □ Athlete's foot □ Excessive body odor □ Excessive sweating □ Fungal infect ions □ Nail problems □ Moles- irregular □ Moles - change/new
KIDNEYS & URINARY TRACT
□ Blood in urine □ Brown urine □ Dribbling after urination □ Painful urination □ Excessive thirst □ Involuntary urination/incontinence □ Urinating frequently (day) □ Urinating frequently (night) □ Urine hesitancy □ Weak flow □ Frequent bladder infections □ Kidney disease □ Kidney stone
ENDOCRINE
□ Diabetes □ Sickle cell □ Abnormal body hair □ Changes in skin texture □ Cold intolerance □ Heat intolerance □ History of "borderline" diabetes
MUSCULOSKELETAL
□ Anemia □ Arthritis □ Back pain □ Bursitis □ Gout □ Joint aches □ Neck pain □ Tendinitis □ Abnormal Blood Counts □ Blood clots in legs/lungs □ Bone Marrow Biopsy □ Easy Bleeding □ Easy bruising □ Joint swelling □ Morning stiffness □ Muscle aches
GASTROINTESTINAL
□ Diarrhea □ Reflux □ Ulcers □ Hepatitis □ Abdominal pain □ Anal fissures □ Black tarry stools □ Vomiting blood □ Constipation □ Nausea □ Problems swallowing □ Hiatal Hernia □ Intestinal obstruction □ Liver disease □ Hemorrhoids □ Red blood after bowel movements □ Gallstones □ Vomiting □ Heartburn □ Indigestion
MALE & FEMALE
□ Painful sexual intercourse □ Loss of sexual interest □ Unprotected sex □ Groin itching □ Sexually transmitted diseases
MALES ONLY
□ Hernia □ Sterility □ Bloody ejaculation □ Inability to complete intercourse □ Lump on testicle □ Penile discharge □ Problems maintaining or keeping an erection □ Prostate disease □ Sores on penis or warts □ Testicular pain □ Testicular swelling
FEMALES ONLY
□ D & C □ Hot flashes □ Hernia □ Fibroids □ Abnormal bleeding between cycles □ Abnormal pap smear □ Bleeding after intercourse □ Complications w/pregnancy □ PMS □ Endometriosis □ Heavy bleeding during cycles □ Discharge from breast □ Ovarian cysts □ Pelvic Inflammatory Disease □ Postmenopausal symptoms □ Vaginal discharge □ Vaginal Dryness □ Vaginal warts

Not Listed Above: _____

_____
I the above signed affirm the above is t rue (*patient signature)* date

Provider's Comments:_____

_____

_____
Print Provider's Name date
History Documentation - Review of Systems: ***99202 = P/N for system 99203 = 2-9 systems 99204/99205 = 10 systems***