

MORRISON CHIROPRACTIC, P.A.

Gentle, Effective, Quality Chiropractic Care

Confidential Case History- **Please Print. Complete Both Sides**

Patient Type: **New Patient** **Existing Patient- New Injury/Episode**

Name: _____ Date of Birth: _____ Pt# _____

Primary Care Physician: _____ Phone: _____

Referred by: _____

Main Complaint: Why are you here today? _____

Work Related Injury? Y N Auto Accident? Y N Injury at Home? Y N

When did it start? Date: _____ How did it start? _____

How many times in the past have you had the same or a similar pain/problem? 0 1-2 3-4 5 or more

Are you currently out of work due to this problem? Y N If yes, when did disability begin? _____

Did it begin gradually or suddenly? _____

Has your pain been getting better or worse? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Does the pain radiate to any other part of your body? _____

Is your pain worse in the morning, afternoon, evening, night, same all day? _____

What doctors have you seen and tests have you done for this condition? _____

What medication or home remedies have you tried for this problem? _____

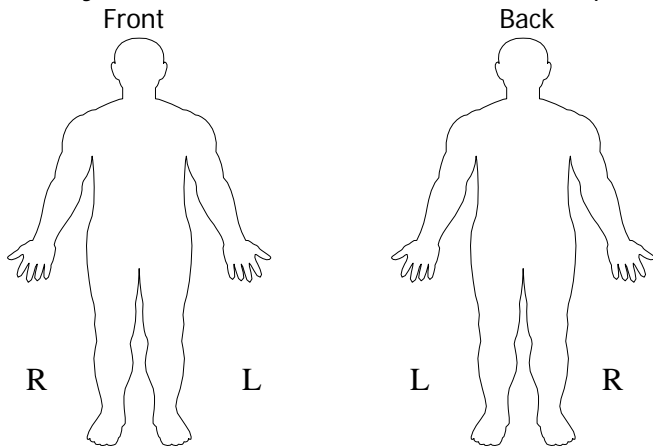
Have there been any other changes in any body functions? Y N Explain: _____

Has your condition affected your daily activities or work in any way? Y N Explain: _____

Do you have any other problems that you would like to have the doctor evaluate? _____

Is your pain __constant (76-100%) __ freq. (51-75%) __ occas. (26-50%) __intermittent (25%- or less)?

Mark your areas of discomfort: (indicate: /// pain, O pins & needles, X ache, = = = numbness)



- | |
|--------------|
| Is your pain |
| __ sharp |
| __ dull |
| __ achy |
| __ weak |
| __ throbbing |
| __ numb |
| __ shooting |
| __ gripping |
| __ burning |
| __ tingling |

Indicate the range of intensity of your pain: no pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain

Indicate how you rate your pain right now: 0 1 2 3 4 5 6 7 8 9 10

Morrison Chiropractic Confidential Case History Continued...

Patient Name: _____ Date of Birth: _____

Are you experiencing any of the following? Circle any that apply. Circle "NA" if none apply

Head and neck: Headaches, visual changes, difficulty with taste, smell or swallowing. None apply.

Heart: Chest pain, irregular, rapid or pounding heart beat, rapid heart beat, swelling, fainting spells, orthopnea, history of heart disease. NA.

Lungs: Shortness of breath, cough, phlegm, wheeze, blood in sputum. NA.

Gastrointestinal: Difficulty swallowing, stomach pain, nausea, heartburn, change in bowel habits, blood in stool. NA.

Urogenital: Pain, increased frequency or urgency, discharge, blood in urine, polycystic kidney, NA.

Neurological: Weakness, numbness, loss of sensation in the face, arms, hands, fingers, legs, in-coordination, difficulty walking, dizziness, blurred vision, double vision, diminished or partial loss of vision in one or both eyes, involuntary eye movements, slurred speech, temporary confusion, ringing in ears, loss of consciousness or blackouts, hearing loss. NA.

Musculoskeletal: Joint pain, swelling, stiffness, weakness, bone spurs in neck or back, history of whiplash. Ehlers-Danlos or Marfan Syndrome, Fibromuscular Dystrophy, NA.

Psychosocial: Depression, anxiety, recent stressors, change in lifestyle, NA.

Circulatory: Bleeding problems, swollen glands, fluid retention, high blood pressure, hardening of the arteries, blood vessel disease, personal or family history of stroke, fainting or collapse, NA.

Have you been diagnosed with any other health conditions: Y N Explain: _____

Are you under a doctor's care for any other health problems? Y N Explain: _____

Have you had any broken bones? Y N Which ones? _____

Have you had any significant auto or work injuries or falls? Y N When? _____

Are you taking any medications? Y N Please list: _____

Have you had surgery? Y N List type and date: _____

Do you smoke, drink alcohol or use recreational drugs? Y N Which? _____

Have you smoked in the past? Y N

Do you have any allergies? _____

Do any diseases run in your family? _____

MEN: Difficulty with urination? Y N Excessive Urination Y N Date of last prostate exam: _____

WOMEN: Birth Control Pills: Y N Menstrual Pain: Y N Cramps: Y N Irregularity: Y N

Are you pregnant? Y N Due _____

My answers on this form are accurate to the best of my knowledge. I hereby consent to any procedures or treatments necessary for treatment of any conditions as deemed reasonable by the attending doctor.

Patient Signature: _____ Date: _____