

CASCADE CHIROPRACTIC

PATIENT MEDICAL RECORD

Confidential information required for case history file

PATIENT: _____ Date: _____
Last Name: _____ First Name: _____ Middle: _____
Address: _____ Apartment: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Social Security #: _____
Gender: M F Date of Birth: _____ Age: _____ Marital Status: M S W D
Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
How did you hear about our clinic or who referred you? _____

SPOUSE or GUARDIAN:
Last Name: _____ First Name: _____ Middle: _____
Employer: _____ Work Phone: _____
Date of Birth: _____ Age: _____ Social Security #: _____

INSURANCE:
Insurance Company: _____
Insured Name: _____ Member #: _____
Insurance Company: _____
Insured Name: _____ Member #: _____

MAJOR COMPLAINTS:
Describe your major complaint in detail: _____

Date when condition first started: _____
Cause of pain, if known: _____
Is this condition due to an accident? Y N Date: _____
Auto: ___ Work Related: ___ Fall: ___ Other: _____
Have you been treated for this condition? Y N If yes when? _____
Name of treating physician: _____ What was done? _____
Have you had a similar condition before? Y N If yes when? _____
Were you treated? Y N If yes by whom: _____

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List all medication, vitamins, and minerals, etc. you are taking: _____

Have you had x-rays in the last 6 months? Y N Where? _____

Which of these factors affect your condition (please check all that apply)?

	No Effect	Better	Worse		No Effect	Better	Worse
<u>Movement</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>End of the day</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Sitting</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>During heavy activity</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Standing</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>While resting</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Walking</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Before meals</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Lying Down</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>During meals</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>During the night</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>After meals</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>First thing in morning</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>2-4 hours after meal</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYMPTOMS: Check the following which you have had and underline any you have now.

GASTROINTESTINAL

- Constipation
- Diarrhea
- Digestive problems
- Stomach pain
- Vomiting of blood
- Gall bladder trouble
- Hemorrhoids
- Liver trouble

SKIN

- Bruising
- Boils
- Dryness

GENITOURINARY

- Frequent urination
- Painful urination
- Difficulty starting urine
- Inability to control urine
- Blood in urine
- Bed wetting
- Kidney infection
- Prostate trouble

MUSCLES AND JOINTS

- Foot problems
- Swollen joints
- Hernia

CARDIO VASCULAR

- High blood pressure
- Low blood pressure
- Previous heart trouble
- Previous stroke

FOR WOMEN ONLY

- Cramps Backache
- Excessive flow
- Hot flashes
- Irregular cycles
- Painful intercourse
- Painful menstruation
- Vaginal discharge

RESPIRATION

- Chest pains
- Chronic cough
- Difficulty breathing
- Frequent colds

Spitting blood

- Allergies general
- Weight loss
- Nervousness
- Emotional issues

Date of last physical

EYES-EARS-NOSE

- Eye pain
- Earaches
- Ear discharge
- Ringing of ears
- Nasal discharge
- Nose bleeds
- Sinus trouble
- Difficulty swallowing
- Hoarseness
- Asthma

Date of last exam

PATIENT PAIN DRAWING

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching △△△

Numbness

Pins & Needles ○○○

Burning XXX

Stabbing ↘↘↘

Other ○○○

Pain in arm(s)

Compared to Neck:

Worse Than

Same As

Less Than

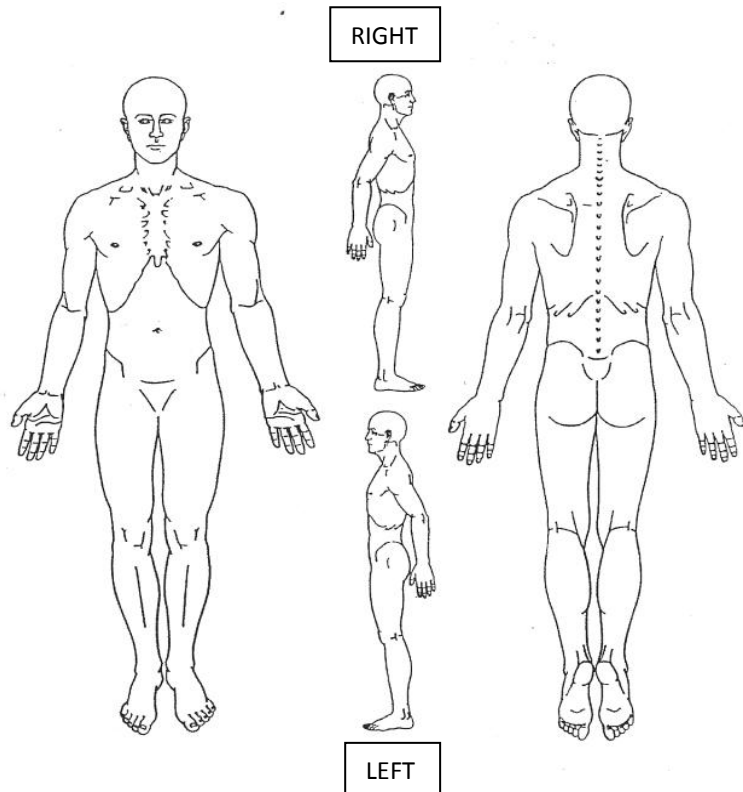
Pain in leg(s)

Compared to Back:

Worse Than

Same As

Less Than



Please put a mark on the scale to show how bad your usual discomfort has been recently. If you are describing more than one symptom, indicate the level of pain for each symptom.

No discomfort									Worst Possible Discomfort	
1	2	3	4	5	6	7	8	9	10	

HISTORY:

Does your mother, father or siblings have any of the following conditions? Diabetes___ Cancer___
 TB___ Heart Disease___ High Blood Pressure___ Low Blood Pressure___ Hypoglycemia___

Other: _____

Weight: _____ Gained or lost in the last five years? _____

Have you had previous chiropractic care? Y N By whom? _____

When? _____

Please list any MAJOR accidents, falls, injuries and other related accidents with dates: _____

List any type of surgeries with dates: _____

List any major illnesses: _____

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PAYMENT IS EXPECTED AT THE TIME OF THE VISIT

Payment is to be made at the time of the visit. Any other arrangement must be made in advance of the appointment between the patient, doctor/front desk. Furthermore a 24 hour cancellation notice is required to enable us to fill the appointment time. Also, insurance policies are the arrangement between the carrier and the patient. We will help prepare any necessary reports on a periodic basis. However, it should be understood that all services performed are charged to the patient and payment is due at the time of service.

SIGNATURE: _____