

# Family Chiropractic

Date: \_\_\_/\_\_\_/\_\_\_

## Personal Information

First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Nickname : \_\_\_\_\_ Email(confidential): \_\_\_\_\_

Driver's Lic # \_\_\_\_\_ State \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Childr.Names/Ages: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation/Title: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Is it OK to contact you @ work? Y N Emergency only

Work Address \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Occasionally, the Doctor may need to contact you about your care...best time to contact you? \_\_\_\_\_

Best Weekdays / Time frames for appointments w/ us? \_\_\_\_\_

Marital Status: Single Married Divorced Separated Widowed Cohabiting Other: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse's D.O.B. \_\_\_\_\_ Spouse's Emplr: \_\_\_\_\_

### Primary Physician Information:

Doctor's Name: \_\_\_\_\_ Office Name \_\_\_\_\_

Addr: \_\_\_\_\_ Appox. date of last visit \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Website: \_\_\_\_\_

Emergency Contact (Name/Phone): \_\_\_\_\_

How did you hear about our office? (if yellow pgs, specify book) \_\_\_\_\_

When did you LAST receive chiropractic care (NEVER) ? \_\_\_\_\_ For? \_\_\_\_\_

Have all your Chiropractic experiences been: N/A Good Not So Good Other: \_\_\_\_\_

Have you ever received Chiropractic care for 2 months or more, consistently? \_\_\_\_\_

Do you have any plans to be out of town or travel within the next 30 days? Y N \*For how long? \_\_\_\_\_

**\*Valued Patients:** To keep the cost of your health care at an affordable fee, Family Chiropractic remains a **zero balance** facility. This means we do not bill our patients or send monthly statements unless necessary. Co-pays, Co-insurances, Deductibles, or Self-Pay payments are expected at each visit, unless Pre-paid.

**\*\*Scheduling Appointments:** Family Chiropractic understands that circumstances/emergencies can prevent our patients from keeping their scheduled appointments. Therefore, if you cannot keep your scheduled appointment PLEASE CALL OUR OFFICE ASAP to notify us that you are on your way or to Reschedule. Thank You  
WE RESERVE THE RIGHT TO CHARGE YOU FOR "NO-SHOW" APPOINTMENTS. I agree and initial here: \_\_\_\_\_

Family Chiropractic P.O. Box 1375 Denver, NC 28037(704) 489.2273/F704.489.2274

# Family Chiropractic

## Confidential Case History

O – Occasional F – Frequent C – Constant

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Using the Key above, check those symptoms you do have or have had in the past year. Leave it blank if you haven't had it. Also, CIRCLE THE CONDITION if you are being/have been treated for it.

	O	F	C		O	F	C		O	F	C
Allergies	___	___	___	Burps /Gas	___	___	___	Loss of Balance	___	___	___
Chills	___	___	___	Colitis / I.B.S.	___	___	___	High Blood Pres	___	___	___
Convulsions	___	___	___	Sm.Intest/Colon	___	___	___	Low Blood Pres	___	___	___
Dizziness	___	___	___	Constipation	___	___	___	Blood Clot Prob.	___	___	___
Fainting	___	___	___	Diarrhea	___	___	___	Circultion Prob	___	___	___
Fatigue	___	___	___	Digestive Issues	___	___	___	Fast/Slow Heart	___	___	___
Fever	___	___	___	Abdmnl Cramps	___	___	___	Swollen Ankles	___	___	___
Headache	___	___	___	Celiac Disease	___	___	___	Varicose Veins	___	___	___
Loss of Sleep	___	___	___	Gall Bladder	___	___	___		O	F	C
Weight Loss	___	___	___	Hemorrhoids	___	___	___	Chest Pain	___	___	___
Nervousness	___	___	___	Abn Eatng/Hungr	___	___	___	Chronic Cough	___	___	___
Depression	___	___	___	Jaundice	___	___	___	Breathing Probs	___	___	___
Neuralgia	___	___	___	Liver Trouble	___	___	___	Spittin up Blood	___	___	___
Numbness	___	___	___	Nausea/Vomitg	___	___	___	SpittinUpPhlegm	___	___	___
Abnorm Sweats	___	___	___	Stomach Probs	___	___	___	Wheezing	___	___	___
Tremors	___	___	___	Poor Appetite	___	___	___		O	F	C
	O	F	C	Dry Mouth	___	___	___	Boils / Blisters	___	___	___
Arthritis	___	___	___	Vomitting Blood	___	___	___	Bruise Easily	___	___	___
Bursitis	___	___	___		O	F	C	Dryness/Cracks	___	___	___
Foot Trouble	___	___	___	Asthma	___	___	___	Sting Sensitivity	___	___	___
Hernia	___	___	___	Colds	___	___	___	Itching	___	___	___
<b><u>Pain In:</u></b>	___	___	___	Double Vision	___	___	___	Skin Rashes	___	___	___
Low Back	___	___	___	Hearing Loss	___	___	___	Warts	___	___	___
Neck	___	___	___	Dental Decay	___	___	___		O	F	C
Upper/Mid Back	___	___	___	Earache	___	___	___	Bed Wetting	___	___	___
Shoulders	___	___	___	Ear Discharge	___	___	___	Blood in Urine	___	___	___
Elbows	___	___	___	Ear Noises	___	___	___	Freq. Urination	___	___	___
Hands/Wrists	___	___	___	Gland Issues	___	___	___	Kidney Infect.	___	___	___
Hips/Buttocks	___	___	___	Thyroid Probs.	___	___	___	Kidney Stones	___	___	___
Fingers/Toes	___	___	___	Eye Pain/Weak	___	___	___	Urination Pain	___	___	___
Knees	___	___	___	Blurry Vision	___	___	___	Prostate Probs.	___	___	___
Ankles/Feet	___	___	___	Far Sighted	___	___	___				
Tailbone	___	___	___	Gum Trouble	___	___	___	<b><u>Women:</u></b>	O	F	C
Poor Posture	___	___	___	Hay Fever	___	___	___	Breast Pain	___	___	___
Sciatica	___	___	___	Hoarseness	___	___	___	Menstr. Cramps	___	___	___
Scoliosis	___	___	___	Nasal Blockage	___	___	___	Heavy Flow	___	___	___
Swollen Joints	___	___	___	Near Sighted	___	___	___	Hot Flashes	___	___	___
TMJ/Jaw Probs.	___	___	___	Nosebleeds	___	___	___	Irregular Cycle	___	___	___
Groin	___	___	___	Sinus Infection	___	___	___	Menopausal	___	___	___
Loss of Taste	___	___	___	Sore Throat	___	___	___	Irreg. Discharge	___	___	___
Loss of Smell	___	___	___	Tonsillitis	___	___	___	Yeast Infections	___	___	___

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Please CIRCLE the follow conditions you have or have had:**

- |              |            |                |                |                 |                  |
|--------------|------------|----------------|----------------|-----------------|------------------|
| Cancer       | Cold Sores | Goiter         | Measles        | Rheumatic Fever | Whooping Cough   |
| Anemia       | Diabetes   | Fever Blisters | Miscarriage    | Scarlet Fever   | Venereal Disease |
| Appendicitis | Pneumonia  | Heart Disease  | Mult.Sclerosis | Stroke          | Epilepsy         |
| Eczema       | HIV/AIDS   | Mumps          | Tuberculosis   | Polio           | Arthritis: _____ |
| Emphysema    | Influenza  | Pleurisy       | Ulcers         | Breast Lumps    | Arteriosclerosis |
| Crohn's      | Pacemaker  | Aneurysm       | Alcoholism     | Gout            | Other(s): _____  |

Have you been treated for any conditions in the last year?  No  Yes

If yes, please describe \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Is there a chance that you are PREGNANT?  No  Yes # of Wks: \_\_\_\_\_

Have you recently had XR, MRI, or CT taken?  No  Yes \*If yes, where? \_\_\_\_\_

MEDICATIONS you now take: (Please list for what condition, dosage, and frequency, etc) \_\_\_\_\_

Vitamins, Minerals, Herbs, Supplements you now take: (Please list for what condition, dosage, frequency) \_\_\_\_\_

Have you ever:	No	Yes	Briefly Explain
Had broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any auto accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Family History**

Family Member Past & Present Health conditions(Example: heart disease, cancer, diabctes, arthritis, etc.)

Family Member	Past & Present Health conditions(Example: heart disease, cancer, diabctes, arthritis, etc.)

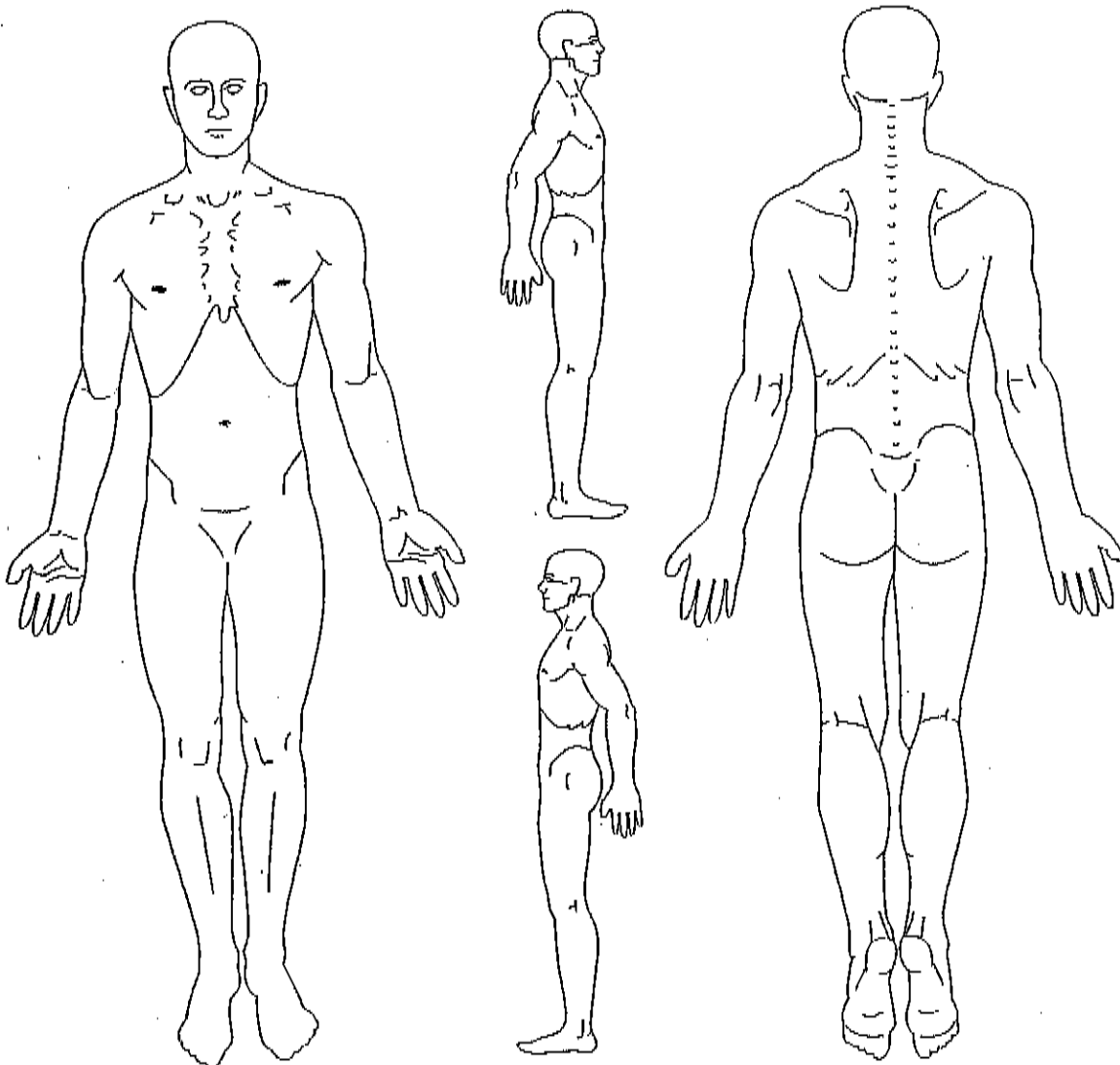
Habits:	None	Light	Moderate	Heavy		Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience daily pain?	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do weather changes affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your symptoms worse at certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does anything prevent you from getting rid of these problems?	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Artifcl Swtnrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Name(Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient ID # \_\_\_\_\_

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

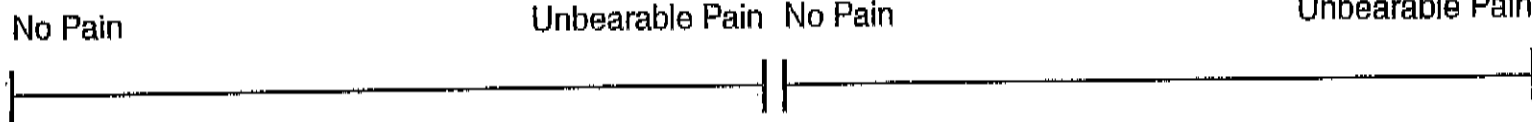
- D** = Dull
- B** = Burning
- N** = Numb
- S** = Stabbing/Cutting
- T** = Tingling (Pins & Needles)
- C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

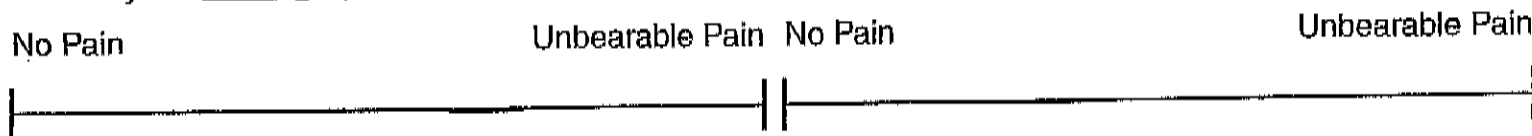
Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:



## NEUROLOGICAL AND VASCULAR QUESTIONNAIRE

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**\*\*For any YES answer PLEASE CIRCLE ANYTHING "IN" THE QUESTION THAT APPLIES...and then on the line below DESCRIBE the Specifics...such as which SIDE of the body, which fingers/toes, etc:**

- |   |    |     |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?    | NO | YES |
| Specifics: _____  |    |     |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands? | NO | YES |
| Specifics: _____  |    |     |
| 3. Do your hands or arms fall asleep regularly?                               | NO | YES |
| Specifics: _____  |    |     |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms? | NO | YES |
| Specifics: _____  |    |     |
| 5. Do you suffer from a loss of hand grip strength?                           | NO | YES |
| Specifics: _____  |    |     |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?     | NO | YES |
| Specifics: _____  |    |     |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?  | NO | YES |
| Specifics: _____  |    |     |
| 8. Do our legs or feet fall asleep regularly?                                 | NO | YES |
| Specifics: _____  |    |     |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?    | NO | YES |
| Specifics: _____  |    |     |
| 10. Do you suffer from cold hands or feet?                                    | NO | YES |
| Specifics: _____  |    |     |
| 11. Do you suffer from headaches, dizziness or memory loss?                   | NO | YES |
| Specifics: _____  |    |     |
| 12. Do you have difficulty maintaining your balance?                          | NO | YES |
| Specifics: _____  |    |     |
| 13. Do you suffer from vertigo or blurred vision?                             | NO | YES |
| Specifics: _____  |    |     |
| 14. Do you suffer from a reduced hearing capacity?                            | NO | YES |
| Specifics: _____  |    |     |
| 15. Do you suffer from ringing in your ears?                                  | NO | YES |
| Specifics: _____  |    |     |
| 16. Do you have bladder or bowel control problems on a regular basis?         | NO | YES |
| Specifics: _____  |    |     |

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**Employment, ADL, and Recreation Information**

Patient Name: \_\_\_\_\_ Case: \_\_\_\_\_ Date: \_\_\_\_\_ Dr: \_\_\_\_\_

Outcomes Assessment Tool Used \_\_\_\_\_ Score \_\_\_\_\_

Description of Work: \_\_\_\_\_

Condition's Effect On Job Performance:  No Effect  Mild Painful (Can do)  Mod Painful (limited ability)  
 Mod/Sev Limited Duty  Sev No Limited Duty  Sev (can't do limited duty)

**Daily Activities: Effects of Current Condition on Performance**

Bending:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Care –Infirm Family:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Carrying Groceries:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Change Posn–Sit-Stand:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Climb Stairs:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Driving:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Extended Computer Use:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Feeding:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Household Chores:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Kneeling:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Lift Children:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Lifting:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Pet Care:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Reading (Concentration):  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Self Care–Bathing:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Self Care–Dressing:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Self Care–Shaving:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Sexual Activities:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Sleep:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Static Sitting:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Static Standing:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Walking:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
 Yard Work:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform

**Recreational Activity: Effects of Current Condition on Performance**

\_\_\_\_\_  No Effect  Mild Painful (Can do)  Mod Painful (limited)  Sev Unable to Perform  
 \_\_\_\_\_  No Effect  Mild Painful (Can do)  Mod Painful (limited)  Sev Unable to Perform  
 \_\_\_\_\_  No Effect  Mild Painful (Can do)  Mod Painful (limited)  Sev Unable to Perform

**QUADRUPLE VISUAL ANALOGUE SCALE**

Patient Name \_\_\_\_\_

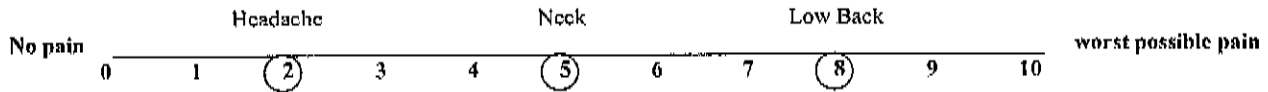
Date \_\_\_\_\_

**Please read carefully:**

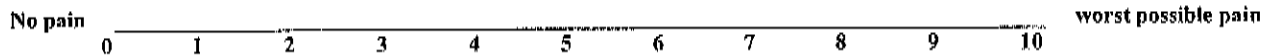
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

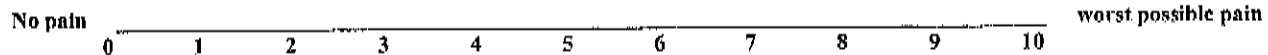
**Example:**



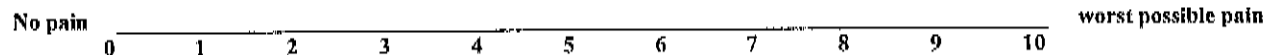
**1 – What is your pain RIGHT NOW?**



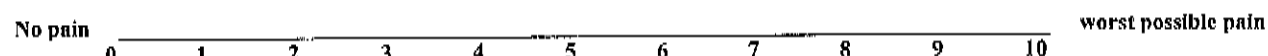
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.