Print Form

# CONFIDENTIAL PATIENT CASE HISTORY

**Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.**

Name _____ Birthday _____ Sex ☐ M ☐ F

Address _____ City/State _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Work _____ Cell _____ E-Mail _____

Marital Status: ☐ M ☐ D ☐ S ☐ W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint?

_____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine Other _____

Other doctors or therapist who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years:

_____

_____

Do you have a family physician? Name _____

Medications, dosage and frequency:

_____

_____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N Describe

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name _____ Number _____ Date _____

**REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.**

| GENERAL | NOW | PAST |
|---|---|---|
| Weakness | ☐ N | ☐ P |
| Fatigue | ☐ N | ☐ P |
| Fever | ☐ N | ☐ P |
| Chills | ☐ N | ☐ P |
| Night Sweats | ☐ N | ☐ P |
| Fainting | ☐ N | ☐ P |
| **SKIN** | | |
| Color Changes | ☐ N | ☐ P |
| Nail Changes | ☐ N | ☐ P |
| Hair Changes | ☐ N | ☐ P |
| Moles | ☐ N | ☐ P |
| Rashes | ☐ N | ☐ P |
| Sores | ☐ N | ☐ P |
| Weakness | ☐ N | ☐ P |
| **HEAD** | | |
| Headaches | ☐ N | ☐ P |
| Injuries | ☐ N | ☐ P |
| Bumps | ☐ N | ☐ P |
| Last Eye Exam | _____ | |
| Glasses | ☐ N | ☐ P |
| Contacts | ☐ N | ☐ P |
| Cataracts | ☐ N | ☐ P |
| **EARS** | | |
| Hard of Hearing | ☐ N | ☐ P |
| Deafness | ☐ N | ☐ P |
| Ringing | ☐ N | ☐ P |
| Discharge | ☐ N | ☐ P |
| Earache | ☐ N | ☐ P |
| Itching | ☐ N | ☐ P |
| Dizziness | ☐ N | ☐ P |
| Room Spins | ☐ N | ☐ P |
| **NOSE** | | |
| Decreased Smell | ☐ N | ☐ P |
| Bleeding | ☐ N | ☐ P |
| Pain | ☐ N | ☐ P |
| Discharge | ☐ N | ☐ P |
| Obstruction | ☐ N | ☐ P |
| Post Nasal Drip | ☐ N | ☐ P |
| Deviated Septum | ☐ N | ☐ P |
| Runny Nose | ☐ N | ☐ P |
| Sinus Congestion | ☐ N | ☐ P |
| **MOUTH** | | |
| Bleeding Gums | ☐ N | ☐ P |
| Sores | ☐ N | ☐ P |
| Dental Problems | ☐ N | ☐ P |
| Bad Breath | ☐ N | ☐ P |
| Loss of Taste | ☐ N | ☐ P |
| Dry Mouth | ☐ N | ☐ P |
| Ulcers | ☐ N | ☐ P |
| Blisters | ☐ N | ☐ P |

| THROAT | NOW | PAST |
|---|---|---|
| Soreness | ☐ N | ☐ P |
| Bad Tonsils | ☐ N | ☐ P |
| Hoarseness | ☐ N | ☐ P |
| Pain | ☐ N | ☐ P |
| Trouble Swallowing | ☐ N | ☐ P |
| Recurrent Infections | ☐ N | ☐ P |
| **NECK** | | |
| Neck Enlargement | ☐ N | ☐ P |
| Stiff Neck | ☐ N | ☐ P |
| Soreness | ☐ N | ☐ P |
| Lumps | ☐ N | ☐ P |
| Masses | ☐ N | ☐ P |
| **BREASTS** | | |
| Discharge | ☐ N | ☐ P |
| Lumps | ☐ N | ☐ P |
| Pain | ☐ N | ☐ P |
| Bleeding | ☐ N | ☐ P |
| Nipple Changes | ☐ N | ☐ P |
| Skin Changes | ☐ N | ☐ P |
| Bloated | ☐ N | ☐ P |
| **LUNGS** | | |
| Cough | ☐ N | ☐ P |
| Phlegm | ☐ N | ☐ P |
| Blood | ☐ N | ☐ P |
| Short of Breath | ☐ N | ☐ P |
| Wheezing | ☐ N | ☐ P |
| Pain | ☐ N | ☐ P |
| Congestion | ☐ N | ☐ P |
| Inhalant Exposure | ☐ N | ☐ P |
| **HEART** | | |
| Murmur | ☐ N | ☐ P |
| Palpitations | ☐ N | ☐ P |
| Rapid Heartbeat | ☐ N | ☐ P |
| Swollen Extremities | ☐ N | ☐ P |
| Cold Extremities | ☐ N | ☐ P |
| Chest Pain/Pressure | ☐ N | ☐ P |
| Varicose Veins | ☐ N | ☐ P |
| Blood Clots | ☐ N | ☐ P |
| Blue Extremities | ☐ N | ☐ P |
| **BLOOD** | | |
| Anemia | ☐ N | ☐ P |
| Low Blood Iron | ☐ N | ☐ P |
| Easy Bruising | ☐ N | ☐ P |
| Easy Bleeding | ☐ N | ☐ P |
| Swollen Nodes | ☐ N | ☐ P |
| Painful Nodes | ☐ N | ☐ P |
| Sugar in Blood | ☐ N | ☐ P |
| Red Spots | ☐ N | ☐ P |

| GASTROINTESTINAL | NOW | PAST |
|---|---|---|
| Abdominal Pain | ☐ N | ☐ P |
| Nausea | ☐ N | ☐ P |
| Bloated | ☐ N | ☐ P |
| Belching | ☐ N | ☐ P |
| Heartburn | ☐ N | ☐ P |
| Indigestion | ☐ N | ☐ P |
| Irregular Bowel Habits | ☐ N | ☐ P |
| Constipation | ☐ N | ☐ P |
| Dirrhea | ☐ N | ☐ P |
| Gas | ☐ N | ☐ P |
| Hemorrhoids | ☐ N | ☐ P |
| Poor Appetite | ☐ N | ☐ P |
| Food Intolerance | ☐ N | ☐ P |
| Bloody Stools | ☐ N | ☐ P |
| Black Stools | ☐ N | ☐ P |
| **GENITOURINARY** | | |
| Urgency | ☐ N | ☐ P |
| Incontinence | ☐ N | ☐ P |
| Straining | ☐ N | ☐ P |
| Back Pain | ☐ N | ☐ P |
| Frequent Voiding | ☐ N | ☐ P |
| Stones | ☐ N | ☐ P |
| Burning | ☐ N | ☐ P |
| Bed Wetting | ☐ N | ☐ P |
| Small Stream | ☐ N | ☐ P |
| Discharge | ☐ N | ☐ P |
| Impotence | ☐ N | ☐ P |
| Dribbling | ☐ N | ☐ P |
| Cloudy Urine | ☐ N | ☐ P |
| Urine Color | _____ | |
| Spotting Between Periods | ☐ N | ☐ P |
| Menstrual Cramps | ☐ N | ☐ P |
| Discharge | ☐ N | ☐ P |
| Itching | ☐ N | ☐ P |
| Painful Intercourse | ☐ N | ☐ P |
| Irregular Periods | ☐ N | ☐ P |
| Hot Flashes | ☐ N | ☐ P |

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐ Heavy ☐ Mod ☐ Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____
Last Prostate Exam _____

**NAME** _____

| NEUROLOGIC | NOW | PAST |
|---|---|---|
| Seizures | ☐ N | ☐ P |
| Vertigo | ☐ N | ☐ P |
| Dizziness | ☐ N | ☐ P |
| Hand Trembling | ☐ N | ☐ P |
| Loss of Sensation | ☐ N | ☐ P |
| Incoordination | ☐ N | ☐ P |
| Loss of Facial | ☐ N | ☐ P |
| Weak Grip | ☐ N | ☐ P |
| Paralysis | ☐ N | ☐ P |
| Difficulty Speech | ☐ N | ☐ P |
| Tingling | ☐ N | ☐ P |
| Loss of Memory | ☐ N | ☐ P |
| Numbness | ☐ N | ☐ P |

| ENDOCRINE | | |
|---|---|---|
| Weight Loss | ☐ N | ☐ P |
| Weight Gain | ☐ N | ☐ P |
| Extremely Thin | ☐ N | ☐ P |
| Heat Intolerance | ☐ N | ☐ P |
| Cold Intolerance | ☐ N | ☐ P |
| Hair Changes | ☐ N | ☐ P |
| Breast Changes | ☐ N | ☐ P |

| IMMUNIZATION/VACCINATION | |
|---|---|
| DPT | Y ☐ |
| Mumps | Y ☐ |
| Smallpox | Y ☐ |
| Typhoid | Y ☐ |
| Tetanus | Y ☐ |
| Measles | Y ☐ |
| Pneumococcal | Y ☐ |
| Influenza | Y ☐ |
| Polio | Y ☐ |
| MMR | Y ☐ |

**BLOOD TYPE**

A + ☐ A - ☐
B + ☐ B - ☐
AB + ☐ AB - ☐
O + ☐ O - ☐
Other _____

**BLOOD TRANSFUSIONS**

Date_____

Date_____

Date_____

Date_____

| PSYCHIATRIC | NOW | PAST |
|---|---|---|
| Hyperventilation | ☐ N | ☐ P |
| Insecurity | ☐ N | ☐ P |
| Depression | ☐ N | ☐ P |
| Troubled Sleep | ☐ N | ☐ P |
| Irritable | ☐ N | ☐ P |
| Undecidedness | ☐ N | ☐ P |
| Timid | ☐ N | ☐ P |
| Hallucinations | ☐ N | ☐ P |
| Loss of Memory | ☐ N | ☐ P |
| Alcoholism | ☐ N | ☐ P |
| Drug Addiction | ☐ N | ☐ P |
| Drug Dependent | ☐ N | ☐ P |
| Suicidal Thoughts | ☐ N | ☐ P |
| Extreme Worry | ☐ N | ☐ P |
| Sexual Problems | ☐ N | ☐ P |

| MUSCULOSKELETAL | NOW | PAST |
|---|---|---|
| Muscle Pain | ☐ N | ☐ P |
| Muscle Weakness | ☐ N | ☐ P |
| Muscle Cramps | ☐ N | ☐ P |
| Muscle Twitching | ☐ N | ☐ P |
| Joint Stiffness | ☐ N | ☐ P |
| Joint Pain | ☐ N | ☐ P |

**PAST MEDICAL HISTORY. Check only the ones you have had in the past .**

| | | | |
|---|---|---|---|
| Hay Fever | Y ☐ | Parasites | Y ☐ |
| Mumps | Y ☐ | Epilepsy | Y ☐ |
| Rheumatic Fever | Y ☐ | Paralysis | Y ☐ |
| Allergies | Y ☐ | Polio | Y ☐ |
| Angina | Y ☐ | Mental Illness | Y ☐ |
| Cancer | Y ☐ | Alcoholism | Y ☐ |
| Tumor | Y ☐ | Depression | Y ☐ |
| Blood Disease | Y ☐ | Nervous Breakdown | Y ☐ |
| Leukemia | Y ☐ | Migraine | Y ☐ |
| Heart Trouble | Y ☐ | Gout | Y ☐ |
| Varicose Veins | Y ☐ | Hemorrhoids | Y ☐ |
| Phlebitis | Y ☐ | Prostate Problems | Y ☐ |
| Hypertension | Y ☐ | Sexual Problems | Y ☐ |
| Stroke | Y ☐ | Gonorrhea | Y ☐ |
| Ulcers | Y ☐ | Syphilis | Y ☐ |
| Jaundice | Y ☐ | Diabetes | Y ☐ |
| Skin Trouble | Y ☐ | Bladder Trouble | Y ☐ |
| Gallstones | Y ☐ | Kidney Stones | Y ☐ |
| Liver Trouble | Y ☐ | Kidney Infections | Y ☐ |
| Hepatitis | Y ☐ | Dysentery | Y ☐ |

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal

Last TB Skin Test _____ ☐ Normal ☐ Abnormal

Allergies: _____

_____

_____

_____

_____

## FAMILY HISTORY List any of the diseases listed above which run in your family.

| Relative | Age if Living | Age at Death | Cause of Death | State of Health | Illnesses |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother(s) | | | | | |
| Sister(s) | | | | | |
| Maternal Grandfather | | | | | |
| Maternal Grandmother | | | | | |
| Paternal Grandfather | | | | | |
| Paternal Grandmother | | | | | |

## SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight?_____ Height _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week _____ Type _____

Smoking ☐ Current ☐ Previous Packs/Day _____ No. of years _____

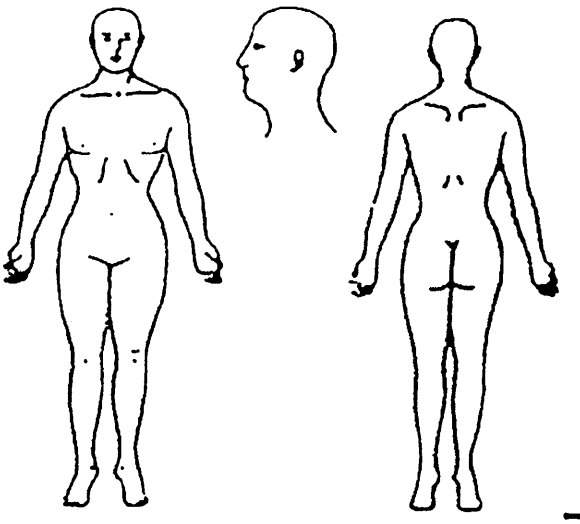
Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine *(Coffee, Tea, Cola)* Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

**MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:**

Aches ^^^^ Numbness oooo Pins/Needles ·••• Stabbing ////



**MARK AN "X" ON THE LINES:**

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe

Patient Name_____ Number _____ Date _____

# Ekengren Chiropractic

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## Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures , disc injuries, stroke, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual cycle is _____.

_____ _____

Patients Name (Printed) Patients Signature

_____ _____

Date Relationship or authority if not signed by patient

_____

Witness