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: ____

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____

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: ____

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

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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
Movement	❑	❑	❑	End of the day	❑	❑	❑
Sitting	❑	❑	❑	During heavy activity	❑	❑	❑
Standing	❑	❑	❑	While resting	❑	❑	❑
Walking	❑	❑	❑	Before meals	❑	❑	❑
Lying Down	❑	❑	❑	During meals	❑	❑	❑
During the night	❑	❑	❑	After meals	❑	❑	❑
First thing in morning	❑	❑	❑	2-4 hours after meal	❑	❑	❑

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

RESPRIATION

__Chest pains
__Chronic cough
__Difficulty breathing
__Frequent colds
__Spitting blood
__Allergies general
__Weight loss
__Nervousness
__Emotional issues

Date of last physical

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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

____

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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 ◯ ◯ ◯

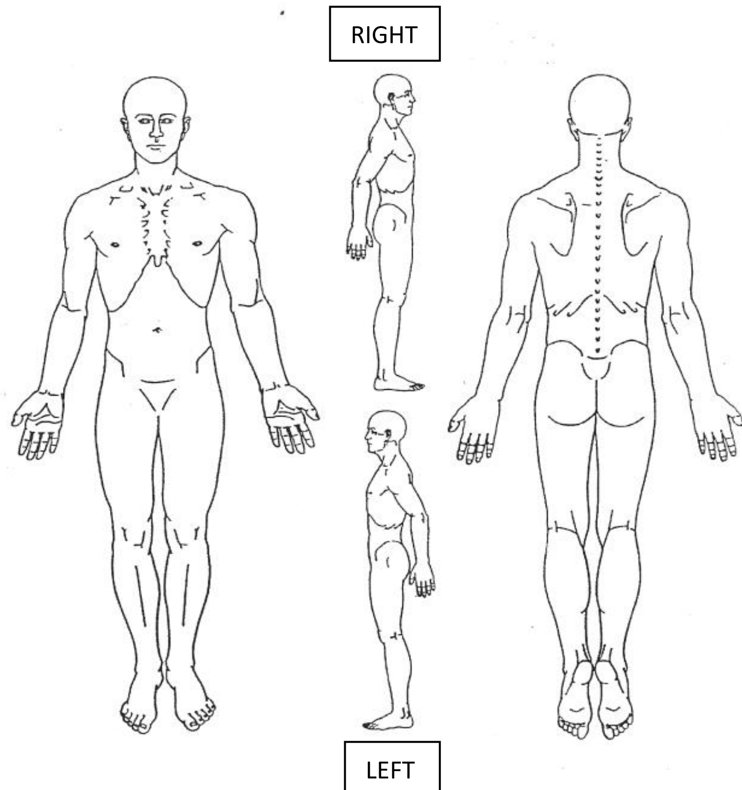
Burning X X X

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: _______________

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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: ____