

Middlesex Spine & Sport Clinic - Confidential Patient Information/Case History

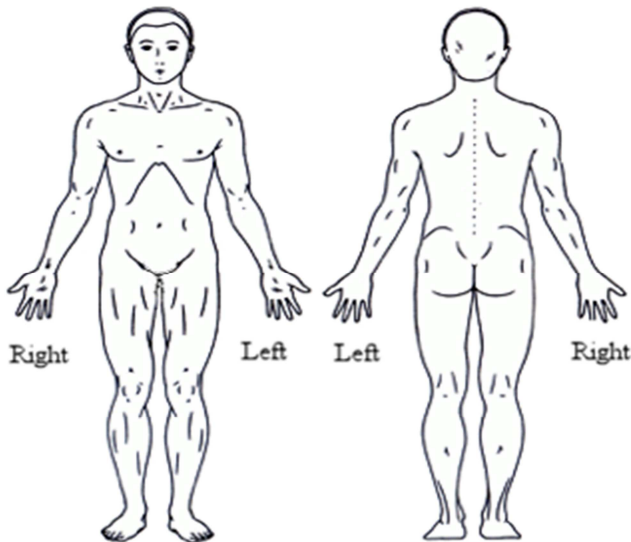
Patient Information:
 Name _____
 Address _____
 City _____ Postal Code _____
 D.O.B (yyyy/mm/dd) _____ Age ____ Sex M / F
 Home Telephone # _____
 Work # _____
 Cell # _____
 Email: _____
 Occupation: _____
 Emergency Contact _____
 Phone # _____
 How did you hear about this office? _____
 Whom may we thank for referring you? _____

Previous Health Care:
 Have you had previous chiropractic care? Yes / No
 Provider's Name _____
 When/Why? _____
 Medical Doctor:
 Name _____
 Address/ Phone # _____
 Date of last physical exam: _____
 Did your medical doctor recommend that you seek chiropractic care? Yes / No
 Is it ok if we communicate with your medical doctor regarding your health condition? Yes / No
 Have you recently had x-rays or imaging? Yes / No
 Date & Location: _____

Chief Complaint:
 Primary Complaint _____

 Other Complaints _____

Is this condition due to a motor vehicle accident? Y / N
 Is this condition due to a work related accident? Y / N
 Please mark all problem areas appropriately:



Sharp /// Burning XXX Dull Ache OOO
 Pins/Needles +++ Numbness ●●●

Please circle the degree of pain (0=None, 10=Extreme)
 0 1 2 3 4 5 6 7 8 9 10

Did the problem come on: Suddenly Slowly
 When (date) did this problem begin? _____
 How did this problem begin (mechanism)? _____

Have you had a similar condition before? Yes / No
 If yes, when? _____
 Is the pain: Improving Unchanging Worsening
 Is the pain: Constant Intermittent
 When does it bother you most? _____

What makes this condition better? _____

What makes this condition worse? _____

Does the pain radiate anywhere? If so, where? _____

What treatments, medications, etc have you tried using for this condition? Did they work? _____

Does this condition interfere with: Sleep Work
 Home life Daily Routine Recreation/exercise
 Is there anything else that you think is relevant or important regarding your condition? _____

Today's Date _____

Middlesex Spine & Sport Clinic - Patient Health History

Please list any previous major illness, injuries, falls, motor vehicle accidents, hospitalizations or surgeries: _____ _____ _____ Please list any medications that you are currently taking or have taken recently _____ _____ _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Social History/Habits</td> <td style="width: 10%;">None</td> <td style="width: 10%;">Light</td> <td style="width: 10%;">Moderate</td> <td style="width: 10%;">Heavy</td> </tr> <tr> <td>Alcohol</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Caffeine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sleep</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Exercise</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Tobacco</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="5">...If yes, how long have you smoked for? _____</td> </tr> <tr> <td>Work Activities</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Standing</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sitting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lifting</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Social History/Habits	None	Light	Moderate	Heavy	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	...If yes, how long have you smoked for? _____					Work Activities					Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Health History - Check off any of the following that **you** currently have or have had in the past (indicate age diagnosed):

<p>General</p> <input type="checkbox"/> Allergies <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Mental illness <input type="checkbox"/> Nervousness <input type="checkbox"/> Tremors <input type="checkbox"/> Vision problems <input type="checkbox"/> Weight loss/gain <p>Muscle/ Joint</p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Weakness <input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Other joint pain: _____ _____	<p>Skin</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Dryness <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Varicose veins <p>Eye/Ear/Nose/Throat</p> <input type="checkbox"/> Colds <input type="checkbox"/> Deafness <input type="checkbox"/> Ear ache <input type="checkbox"/> Eye pain <input type="checkbox"/> Gum trouble <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Ringing of the ears <input type="checkbox"/> Sinus infection <input type="checkbox"/> Sore throat <p>Cardiovascular</p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart palpitation <input type="checkbox"/> Poor circulation	<p>Gastrointestinal</p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloody or tarry stool <input type="checkbox"/> Colitis/ Crohn's disease <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Digestion problems <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Bloating <input type="checkbox"/> Gallbladder problems <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Intestinal worms <input type="checkbox"/> Liver disease <input type="checkbox"/> Nausea <input type="checkbox"/> Painful defecation <input type="checkbox"/> Vomiting of blood <p>Genitourinary</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Prostate problems <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Painful urination <input type="checkbox"/> Urgency to urinate	<p>Respiratory</p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Spitting up phlegm/blood <input type="checkbox"/> Wheezing <p>Women Only</p> <input type="checkbox"/> Breast disease <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Menopause Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks: _____ Number of children: _____ Date of last pap test: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <p>Men Only</p> Have you ever had a prostate exam? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last exam: _____
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Health History - Please check any conditions that you have or have had and indicate the age at which you were diagnosed:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Edema	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gout	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Pace maker	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Neurological Disorders	<input type="checkbox"/> Other

Family History – If any **blood relative** has had any of the following conditions, please check and indicate which relative:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease

Is there anything else that has not been asked that you think is relevant or important in regards to your condition? :

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Objectives of Chiropractic Care- Chiropractic is a safe and natural non-drug, non-surgical approach to better health. Chiropractors improve the function of your muscles, joints and most importantly your nervous system, which controls every other function of your body. Because of this, chiropractic care has helped many people improve their overall health and well-being.

What are your objectives in seeking chiropractic care? (Please check all that apply)

<input type="checkbox"/> Relief of symptoms
<input type="checkbox"/> Improve spinal stability
<input type="checkbox"/> Improve range of motion/ mobility
<input type="checkbox"/> Decrease the risk of symptoms returning
<input type="checkbox"/> Improve nerve function
<input type="checkbox"/> Improve posture
<input type="checkbox"/> Decrease the risk of re-injury
<input type="checkbox"/> Increase energy level
<input type="checkbox"/> Decrease the risk of arthritis
<input type="checkbox"/> Increase athletic performance
<input type="checkbox"/> Relieve stress
<input type="checkbox"/> Improve overall health and well being
Other (Please list): _____

I agree and understand that I am responsible for all charges related to my visit.

Name (please print): _____

Date: _____

Patient Signature/ Legal Guardian: _____