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? _____
_____

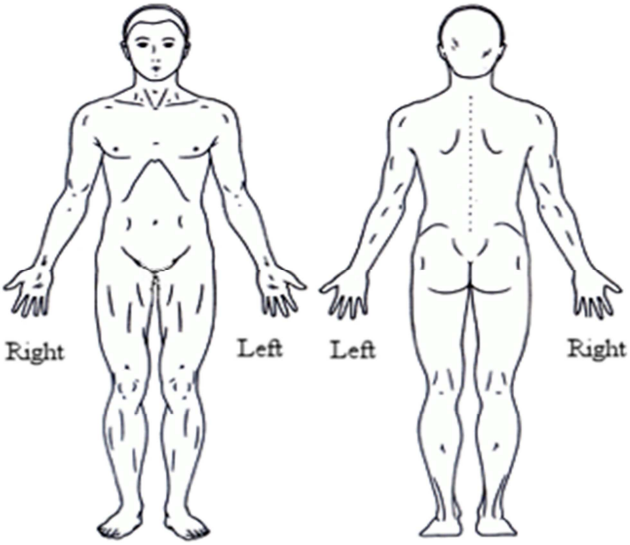
Previous Health Care:
Have you had previous chiropractic care? Yes / No

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_____

_____

_____

_____

Social History/Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

...If yes, how long have you smoked for? _____

Work Activities				
Standing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Lifting	☐	☐	☐	☐

Health History - Check off any of the following that **you** currently have or have had in the past (indicate age diagnosed):

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Vision problems
- ☐ Weight loss/gain

Muscle/ Joint
- ☐ Arthritis
- ☐ Weakness
- ☐ Back pain
- ☐ Neck pain
- ☐ Other joint pain:

_____

Skin
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye/Ear/Nose/Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Atherosclerosis
- ☐ Chest pain
- ☐ Heart palpitation
- ☐ Poor circulation

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis/ Crohn's disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestion problems
- ☐ Diverticulosis
- ☐ Bloating
- ☐ Gallbladder problems
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Liver disease
- ☐ Nausea
- ☐ Painful defecation
- ☐ Vomiting of blood

Genitourinary
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Urgency to urinate

Respiratory
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Spitting up phlegm/blood
- ☐ Wheezing

Women Only
- ☐ Breast disease
- ☐ Vaginal discharge
- ☐ Menopause

Are you currently pregnant? ☐ Yes ☐ No

If yes, how many weeks:

_____

Number of children:

_____

Date of last pap test:

_____

☐ Normal ☐ Abnormal

Men Only

Have you ever had a prostate exam?

☐ Yes ☐ No

Date of last exam:_____

Health History – Please check any conditions that you have or have had and indicate the age at which you were diagnosed:

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

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

☐ Arthritis	☐ Autoimmune Disease	☐ Bleeding Disorder
☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ High Blood Pressure	☐ High Cholesterol	☐ Multiple Sclerosis
☐ Osteoporosis	☐ Stroke	☐ 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)

- ☐ Relief of symptoms
- ☐ Improve spinal stability
- ☐ Improve range of motion/ mobility
- ☐ Decrease the risk of symptoms returning
- ☐ Improve nerve function
- ☐ Improve posture
- ☐ Decrease the risk of re-injury
- ☐ Increase energy level
- ☐ Decrease the risk of arthritis
- ☐ Increase athletic performance
- ☐ Relieve stress
- ☐ 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: _____