# INTRODUCTION PATIENT CASE HISTORY

**Today's Date:** ____/____/_____

PATIENT INFORMATION

**Name:** *(First MI Last)* _____ **Preferred Name:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Date of Birth:** _____ **Gender:** ☐ Male ☐ Female **Social Security #:** _____

**Home:** _____ **Mobile:** _____ **Work:** _____

**Email:** _____

**Preferred Method of Contact:** ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: _____

***Referred By:** *(Name)* _____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____

**Race & Ethnicity:** *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline

**Preferred Language:**

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

EMERGENCY CONTACT INFORMATION

**Name:** *(First MI Last)* _____ **Primary Care Physician:** _____

**Home:** _____ **Mobile:** _____ **Doctor's Phone:** _____

**Relationship:**

☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

FINANCIAL INFORMATION

**Is today's visit the result of an accident?**

☐ No ☐ Auto ☐ Work ☐ Other: _____

**Will we be working with insurance?** ☐ No ☐ Yes *(Details)*

*Primary:* _____ *ID#:* _____

*Secondary:* _____ *ID#:* _____

**Where would you like statements sent?**

☐ Self ☐ Other *(Details below)*

*Name:* _____

*Address:* _____

*Phone:* _____ *Email:* _____

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged***

**Account No:** _____

# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

**Major Complaint:** _____ **Secondary Complaints:** _____

_____ _____

_____ _____

**When did it start?** ___/___/____ **What happened?** _____

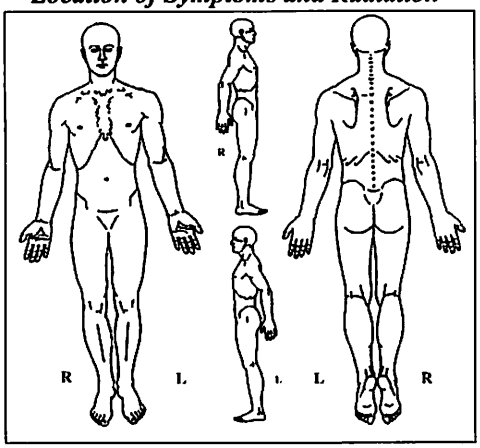
_____

**Which daily activities are being affected by this condition?** _____

_____

## *MAJOR COMPLAINT*

***Location of Symptoms and Radiation***




P __ Pain
N __ Numb
S __ Spasm
T __ Tender
H __ Hypoesthesia

**Grade Intensity/Severity:**

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

**Frequency:**

- ☐ Off & On
- ☐ Constant

**Quality:**

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

**Does it radiate?**

☐ No ☐ Yes *(Please indicate on drawing)*

**Improves with:**

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

**Worsens with:**

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

**Previous Treatment:**

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

**Previous Diagnostic Testing:**

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

***Women:** *Are you pregnant?*

☐ No *Last Menstrual Period:* ___/___/____

☐ Yes *Due date:* ___/___/____

*Present Illness Comments:*

_____

_____

_____

_____

_____

_____

**Prescription Medications & Supplements:** ☐ None

☐ Yes *(List – Name, dosage, frequency)* _____

_____

_____

_____

_____

_____

**Allergies to Medications:** ☐ No known drug allergies

☐ Yes *(List - Name and reaction)* _____

_____

_____

_____

_____

_____

# PAST, FAMILY, AND SOCIAL HISTORY

## PAST MEDICAL HISTORY

**Have you *ever* had any of the following?** *(Please select all that apply and use comments to elaborate.)*

**Illnesses:**

- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) _____
- ☐ Blood Clots
- ☐ Cancer (*Type*) _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

**Injuries:**

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

**Hospitalizations:** *(Non-surgical with Date)*

_____

_____

**Surgeries:** *(If yes, provide type & surgery date)*

- ☐ Cancer _____
- ☐ Orthopedic
  - Shoulder – R / L _____
  - Elbow/Forearm – R / L _____
  - Wrist/Hand – R / L _____
  - Hip – R / L _____
  - Knee – R / L _____
  - Ankle/Foot – R / L _____
- ☐ Spinal Surgery
  - Neck: _____
  - Back: _____
- ☐ Other: _____

_____

_____

*Medical History Comments:*

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## FAMILY HISTORY *(Please mark X to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

| | Mother | Father | Sibling1 | Sibling2 | Sibling3 | Child1 | Child2 | Child3 |
|---|---|---|---|---|---|---|---|---|
| Gender | F | M | | | | | | |
| Age at death *(if Deceased)* | | | | | | | | |
| Aneurysms | | | | | | | | |
| CVA (Stroke) | | | | | | | | |
| Cancer | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Disease | | | | | | | | |
| Hypertension | | | | | | | | |
| Other Family History | | | | | | | | |

*Family History Comments:*

_____

_____

_____

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_____

_____

_____

_____

_____

## SOCIAL AND OCCUPATIONAL HISTORY

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Other

**Children:** ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

**Student Status:** ☐ Full Student ☐ Part Student ☐ Non-Student

**Highest level of Education:** ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: _____

**Employed:** ☐ No ☐ Yes (*Occupation*) _____

**Dominant Hand:** ☐ Right ☐ Left ☐ Ambidextrous

**Smoking/Tobacco Use:** *If current smoker, amount =* _____

☐ Every Day ☐ Some Days ☐ Former ☐ Never

**Alcohol Use:**

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

**Caffeine Use:**

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

**Exercise frequency:**

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

*Social History Comments:* _____

_____

_____

_____

_____

_____

_____

_____

# REVIEW OF SYSTEMS



***Many of the following conditions respond to chiropractic treatment.***

**Are you *currently* experiencing any of these symptoms?** *(Please select all that apply and use comments to elaborate.)*

**Constitutional:** *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: _____
- ☐ *None in this Category*

**Musculoskeletal:**
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

**Neurological:**
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: _____
- ☐ *None in this Category*

**Psychiatric:** *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

**Genitourinary:**
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: _____
- ☐ *None in this Category*

**Gastrointestinal:**
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

**Cardiovascular & Heart:**
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: _____
- ☐ *None in this Category*

**Respiratory:**
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _____
- ☐ *None in this Category*

**Eyes & Vision:**
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: _____
- ☐ *None in this Category*

**Head, Ears, Nose, & Mouth/Throat:**
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: _____
- ☐ *None in this Category*

**Endocrine:**
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: _____
- ☐ *None in this Category*

**Hematologic & Lymphatic:**
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: _____
- ☐ *None in this Category*

**Integumentary:** *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: _____
- ☐ *None in this Category*

**Allergic/Immunologic:**
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: _____
- ☐ *None in this Category*

*Review of Systems Comments:*

_____

*I have answered these questions to the best of my knowledge and certify them to be true and correct.*

Patient or Guardian Signature _____ Date_____

# Functional Rating Index

In order to properly assess your condition, we must understand how much your pain has affected your ability to manage everyday activities. For each item below, please **mark** the number which most closely describes your condition **right now**.

1. Pain Intensity
   0. No Pain
   1. Mild Pain (1-2/10)
   2. Moderate Pain (3-4/10)
   3. Severe Pain (5-7/10)
   4. Worst Possible Pain (8-10/10)

2. Sleeping
   0. No Pain
   1. Mildly disturbed sleep, wakes up 1x due to the pain
   2. Moderately disturbed sleep, wakes up 2x a night
   3. Greatly Disturbed sleep, wakes up 3+ times a night
   4. Totally disturbed sleep, doesn't sleep more than an hour at a time

3. Personal Care (washing, dressing, etc.)
   0. No pain with no restrictions
   1. Mild pain with no restrictions
   2. Moderate pain with a need to go slowly
   3. Moderate pain with a need for some assistance
   4. Severe pain with a need for 100% assistance

4. Travel (driving, riding in the car, etc.)
   0. No pain on long trips
   1. Mild pain on trips longer than 2 hours
   2. Moderate pain on trips longer than one hour
   3. Moderate pain on trips less than 1 hour
   4. Severe pain with any length of trip

5. Work (job, housework, chores, school etc.)
   0. Can do usual work, plus unlimited extra work
   1. Can do usual work, but with mild pain and no extra work
   2. Can do 50 % of their usual work with moderate pain
   3. Can do 25 % of their usual work with moderate pain
   4. Cannot work

6. Recreational Activities
   0. Can do all activities
   1. Can do most activities, but with mild pain
   2. Can do 50% of their usual activity with moderate pain
   3. Can do 25% of usual their activities with moderate pain
   4. Cannot do any activities

7. Frequency of Pain
   0. No Pain
   1. 25% of the day
   2. 50% of the day
   3. 75% of the day
   4. 100% of the day

8. Lifting
   0. No pain with heavy weight
   1. Increased pain with heavy weight, 25+ pounds
   2. Increased pain with moderate weight, 15-25 pounds
   3. Increased pain with light weight, under 10 pounds
   4. Increased pain with any weight

9. Walking
   0. No pain at any distance
   1. Increased pain after 30 minutes of walking
   2. Increased pain after 15 minutes of walking
   3. Increased pain after 5 minutes of walking
   4. Increased pain with ALL walking

10. Standing
    0. No pain after several hours
    1. Increased pain after an hour of standing
    2. Increased pain after standing 30 minutes
    3. Increased pain after 10 minutes of standing
    4. Increased pain with any standing

Score:_____

Name (Printed):_____

Signature:_____

Date:_____

Patient ID:_____

# Oskaloosa Chiropractic Clinic, P.C.

Michael Vander Veen D.C.
211 North J Street Oskaloosa, Iowa 52577
(641)672-2540

**ACKNOWLEDGEMENT:** We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

**AUTHORIZATION:** The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination

**I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:**
***NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.***

| | |
|---|---|
| Patient Name | Patient Number |
| Patient Date of Birth | Date |
| Patient Signature | Witness Signature |
| Personal Representative | Personal Representative Signature |
| Personal Representative Relationship to Patient | |

Oskaloosa Chiropractic Clinic, P.C.
Michael Vander Veen D.C.
211 North J Street Oskaloosa, Iowa 52577
(641)672-2540

Patient Name:_____

Patient D.O.B.:_____ Patient ID: _____

## *Informed Consent for Chiropractic Services*

**I have been <u>informed</u> of the following:**

1. I have been informed that the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound;
2. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations;
3. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury;
4. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location;
5. I have been informed that certain techniques may require close proximity between clinician and patient;
6. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations;
7. I have been informed that it is my responsibility to inform the chiropractor of any condition(s) that would otherwise not come to their attention;
8. I have been informed that the chiropractor has made no guarantee of a positive outcome from treatment; and
9. I have been afforded ample opportunity for questions and answers.

**<u>Therefore, by signing below:</u>**

**I <u>consent</u>** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

**I <u>consent</u>** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____ Date: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

**Oskaloosa Chiropractic Clinic, P.C.**
Michael Vander Veen D.C.
211 North J Street Oskaloosa, Iowa 52577
(641)672-2540

Patient Name: _____

Patient ID: _____ Patient D.O.B: _____

## Radiology Consent

I have been explained the recommended radiology procedures, the potential risks and options. I understand the clinical necessity of having x-rays taken at this time and give my consent/permission for this procedure. In so doing I release the Doctor from responsibility, known and unknown, for potential damage arising from this procedure.

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I again understand the clinical necessity of having x-rays taken at this time and give my consent/permission for this procedure. At the present time (please check one):

_____ I am sure that I am not pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

Patient Signature: _____ Date: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____