JOHNSON FAMILY CHIROPRACTIC

3227 N. Prospect Rd., Peoria, IL 61603 (309) 688-8773

CONFIDENTIAL PATIENT CASE HISTORY

Date______________

Legal Name____ **SS#**______________________
LAST FIRST MI

Address_________________________________ **City**________________ **State**_____ **Zip**____________

Home Phone_________________ **Work Phone**__________________ **Cell Phone**__________________

Email Address____________________________________ **Age**_________ **Birthdate**_________________

Employer______________________ **Marital Status**________ **Spouse's Name**___________________

How did you hear about us? Referred by _________________ Yellow pages_____ Internet search_____

****

Have you had previous chiropractic care?________ **When**__________________

Name of Chiropractor_____________________________ **City**__________________________________

<u>Major</u> complaint today____

When did it begin or accident happen?____

How extreme are your current symptoms? 0 1 2 3 4 5 6 7 8 9 10
ABSENT UNCOMFORTABLE AGONIZING

How often do you feel it?____

What does it feel like? (Ex: ACHE, BURN, DULL, NAGGING, PINCH, PULL, SHARP, STIFF, SHOOTING, STAB, STING, THROB, TIGHT)

____

Where does it hurt?____

Does it affect other areas of your body? Does it radiate?___________________________________

What makes it better?____

What makes it worse?____

Is it getting better, getting worse, or remaining constant?_________________________________

What treatment have you already received for this condition?______________________________

Have you had similar problems in the past?____

How does your condition interfere with your:

Work or career____

Recreational activities____

Household responsibilities____

Personal relationships____

Sleep____

What else should Dr. Johnson know about your condition?___________________________________

____

Any other complaints?____

List any surgical procedures and dates of each:_______________________________

____

List drugs/vitamins/herbal supplements you are now taking (Rx & Over-the-counter)________

____

Do you smoke? Y N ____packs per day **Do you drink alcohol?** Y N _____drinks per week

Have you been in an automobile accident? This Year___ Past 5 years ___ 5+ years ___ Never___

Describe the accident(s)____

List other injuries____

Last physical examination date___________________

List allergies____

Are you pregnant? Y N Last menstrual period date____________________

ACTIVITIES OF DAILY LIVING

How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	O	O	O	O	Grocery shopping	O	O	O	O
Rising from chair	O	O	O	O	Household chores	O	O	O	O
Standing	O	O	O	O	Lifting objects	O	O	O	O
Walking	O	O	O	O	Reaching overhead	O	O	O	O
Lying down	O	O	O	O	Showering or bathing	O	O	O	O
Bending over	O	O	O	O	Dressing myself	O	O	O	O
Turning over in bed	O	O	O	O	Reading	O	O	O	O
Using a computer	O	O	O	O	Getting to sleep	O	O	O	O
Getting in/out of car	O	O	O	O	Staying asleep	O	O	O	O
Driving a car	O	O	O	O	Concentrating	O	O	O	O
Caring for family	O	O	O	O	Exercising	O	O	O	O
Looking over shoulder	O	O	O	O	_______________	O	O	O	O
Yard work	O	O	O	O	_______________	O	O	O	O

In additional to the main reason for your visit today, what additional health goals do you have?

____

____

____ _______________

Signature *Date*

FAMILY HISTORY

M = Mom D=Dad S=Sibling

Aneurysm ____
Arthritis ____
Asthma ____
Autism ____
Bi-Polar Disorder ____
Cancer (Describe) ____
Diabetes ____
Digestive Problems ____
Ear Infections ____
Emphysema ____
Epilepsy ____
Gall Stones ____
Headaches ____
Heart Trouble ____
High Blood Pressure ____
Kidney Problems ____
Liver Problems ____
Lung Problems ____
Migraine ____
Obesity ____
Osteoporosis ____
Scoliosis ____
Seizures ____
Stomach Problems ____
Stroke ____
Thyroid Problems (Describe) ____
Vascular Problems (Describe) ____

PAST TREATMENTS

What other treatments have you had, of any kind?

____

____

____

____

____

____

PAST CONDITIONS

What other health conditions have you had, of any kind?

____

____

____

____

____

____

"To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern."

______________________________________ ______________

Signature *Date*