Preston Chiropractic and Rehabilitation, LLC.

Case History

Please Print

History of Present Illness

Approximately when did the conditions or symptoms begin to occur? _____ (date)

Is this the result of a work injury? ☐ Yes ☐ No Or an Auto Accident? ☐ Yes ☐ No

Describe the conditions, symptoms or purpose of the appointment: _____

Social

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Number of packs (per week) _____ Number of drinks (per week) _____

Female patient: **Are you pregnant?** ☐ Yes ☐ No ☐ Unsure but could be

Date of last menstrual cycle: _____ ☐ Regular ☐ Irregular ☐ Using Birth control?

Medications

Please list any current medications:

☐ I will provide a list of medications.

1 _____ Prescribed for: _____

2 _____ Prescribed for: _____

3 _____ Prescribed for: _____

4 _____ Prescribed for: _____

Allergies

Please list any known allergies, and allergies to medications.

1 _____ 3 _____

2 _____ 4 _____

Past Medical History

List any past surgeries (including appendix, tonsils, wisdom teeth, etc)

1 _____ 2 _____

3 _____ 4 _____

List any other hospitalizations & when & for what _____

List any major or minor falls & when they occurred _____

List any cracked or broken bones & when they occurred _____

Vitals

To be filled in by the office staff.

Height	**Weight**	**Blood Pressure**	☐ Right ☐ Left	**Pulse**	☐ **Right handed**
_____ ins.	____ lbs	____ / ____ mmHG	☐ seated?	_____ BPM	☐ **Left handed**

Print Name: _____ **D.O.B.** ____ / ____ / ____

Signed: _____ **Date** ____ / ____ / ____

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Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the patient ever had the same or similar symptoms to this condition? ☐ Yes ☐ No

When? ___/___/___

Describe _____

_____

_____

_____

Please indicate any other healthcare providers who the patient has seen for the condition:

Name	Type of Licensure	Date of Last Visit
		___/___/___
		___/___/___

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Review of Systems

Have you experienced any of the below symptoms in the past 2 weeks or since your last visit?

☐ Headache	☐ Tension	☐ Neck Stiff	☐ Pain in legs/feet
☐ Loss of Memory	☐ Loss of Smell	☐ Face flushed	☐ Sharp / shooting pain
☐ Hands Cold	☐ Burning muscle pain	☐ Nervousness	☐ Neck pain
☐ Numbness arms/hands	☐ Light bothers eyes	☐ Fainting	☐ Ears ring
☐ Coldsweats	☐ Feet cold	☐ Pain in arms/hands	☐ Back pain
☐ Irritability	☐ Tingling in legs/feet	☐ Difficulty swallowing	☐ Loss of Balance
☐ Loss of Strength - Arms	☐ Constipation	☐ Head seems too heavy	☐ Fatigue
☐ Dizziness	☐ Shortness of Breath	☐ Tingling in arms/hands	☐ Jaw pain
☐ Clumsiness	☐ Chest pain/rib pain	☐ Nausea	☐ Other _____
☐ Sleeping Problems	☐ Loss of strength - legs	☐ Numbness legs/feet	_____
☐ Buzzing in ears	☐ Diarrhea	☐ Fever	_____

Changes in Systems

Have you experienced changes to any of the following?

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder

☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite Please Explain: _____

Have you been diagnosed with or experienced any of the following?

☐ Fatigue ☐ Depression ☐ Osteopenia/Osteoporosis ☐ Heart Disease ☐ Stroke ☐ Tuberculosis

☐ Obesity ☐ Diabetes ☐ Spinal Degeneration ☐ Autoimmune Disorder (List) _____

☐ Prostate Disorder ☐ Kidney problems ☐ High blood pressure ☐ COPD ☐ Cancer (List) _____

☐ Thyroid Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder ☐ Smoker ☐ Other (List) _____

Print Name: _____ **D.O.B.** ___/___/___

Signed: _____ **Date** ___/___/___