# Monmouth Chiropractic Clinic

## PATIENT CASE HISTORY

312 East Archer Avenue, Monmouth, IL 61462

**Patient Name:** _____

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

**Zip Code:** _____ **Home Phone:** _____ **Cell Phone:** _____

**Date of Birth:** _____ **Social Security Number:** _____

**Email:** _____ **Occupation:** _____

**Parent/Guardian Occupation:** _____ **Student** ☐ **Employed** ☐

**Employer:** _____ **Work Phone:** _____

**Emergency Contact:** _____

Name Relationship Phone Number

*CMS Requires providers to report both race and ethnicity:*

**Height:** _____ **Weight:** _____ **Blood Pressure:** _____ **Heart Rate:** _____

**Preferred Language:** _____ **Gender:** Male – Female

**Marital Status:** Married / Single / Divorced / Partner / Widow / Widower

**Smoking Status:** Never Smoked / Ex-Smoker / Current Every Day Smoker / Current Someday Smoker

**Race:** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity:** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Preferred method of communication for patient reminders?** Phone / Email / Mail

**Are you taking any vitamins/supplements? (Please List)** _____

**Are you taking any Medications? If yes, please write the name and town of your pharmacy:**

**Do you have any medication allergies?** _____

**Date of last physical examination?** _____

**Do you drink alcohol? How much per week?** _____

**Do you drink caffeine? How much per week?** _____

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care)*

**Do you exercise? What type and how much per week?** _____

**List any surgeries:** (Back, Brain, Knee, Hip, Neck, Elbow, Shoulder, Wrist, Gallbladder, Appendix, Etc.)

## Circle / List ALL Past Medical History Conditions For Yourself and Family:

**Self (S) – Mother (M) – Father (F) – Sibling (Si)**

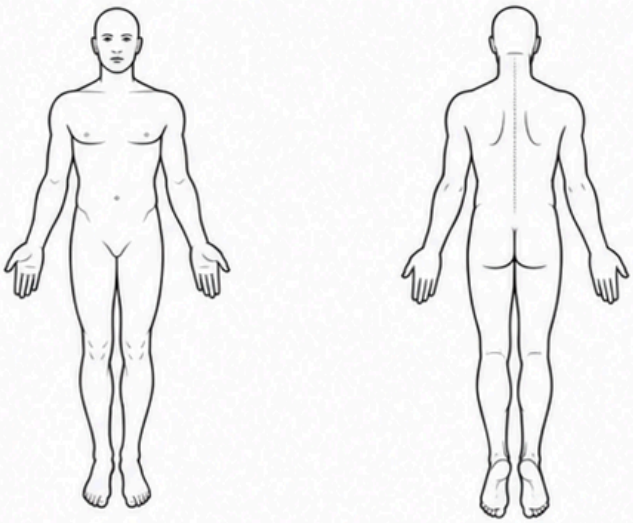
___ Ankle Pain, ___ Arm Pain, ___ Arthritis, ___ Asthma, ___ Broken Bones, ___ Cancer, ___ Chest Pain,
___ Depression, ___ Diabetes, ___ Dizziness, ___ Elbow Pain, ___ Epilepsy, ___ Eye/Vision Problems,
___ Fainting, ___ Fatigue, ___ Foot Pain, ___ Genetic Spinal Condition, ___ Hand Pain, ___ Headaches,
___ Hearing Problems, ___ Hepatitis, ___ High Blood Pressure, ___ Hip Pain, ___ HIV, ___ Jaw Pain,
___ Joint Stiffness, ___ Knee Pain, ___ Leg Pain, ___ Menstrual Problems, ___ Mid-Back Pain,
___ Minor Heart Problems, ___ Multiple Sclerosis, ___ Neck Pain, ___ Neurological Problems, ___ Pacemaker,
___ Parkinson's, ___ Polio, ___ Prostate Problems, ___ Shoulder Pain, ___ Significant Weight Change,
___ Spinal Cord Injury, ___ Sprain/Strain, ___ Stroke/Heart Attack

**Have you had any Auto or Other Accidents? – If yes, please describe:** _____

**Do you have any children? Yes** _____ **No** _____ **Ages?** _____

**Do you wear heel lifts or arch supports?** _____

## Please Mark Your Areas of Pain on the Diagram Below:



Front Back

**Date symptoms began:** _____

**Briefly describe your symptoms:** _____

*(Sharp – Dull – Numb – Burning – Shooting – Tingling – Radiating Pain – Tightness – Stabbing – Throbbing)*

**How did your symptoms start:** _____

**Is this a recurring problem:** _____

**Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)**

## Pain Rating Scale

| 0 | 2 | 4 | 6 | 8 | 10 |
|---|---|---|---|---|---|
| No Hurt | Hurts Little Bit | Hurts Little More | Hurts Even More | Hurts Whole Lot | Hurts Worst |

**No Pain** **Mild Pain** **Moderate Pain** **Severe Pain**

**Average pain intensity during the last 24 hours (circle one):** 1 2 3 4 5 6 7 8 9 10

**Average pain intensity during the last week (circle one):** 1 2 3 4 5 6 7 8 9 10

**How often do you experience your symptoms? (circle one):**

Constantly (76%-100%) Frequently (51%-75%)

Occasionally (26% - 50% of the time) Intermittently (0%-25%)

**How much have your symptoms interfered with your usual daily activities? (circle one):**

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

**How is your condition changing since care began at this facility? (circle one):**

1. N/A – Initial visit 2. Much worse 3. Worse 4. A little worse 5. A little better 6. Better 7. Much better

**In general, would you say your overall health right now is: (circle one):**

1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

**What activities aggravate your condition (working, exercise, etc.):** _____

_____

**What makes your pain better?** _____

**Patient Signature:** _____ **Date:** _____

**Parent/Guardian Signature:** _____ **Date:** _____