Dr. Poane's Chiropractic Office
drpoane.com

Chiropractic Case History

New Patient: *defined as a person new to this office; patient who has not been treated by Dr. P. for 3 yrs.*
Update is defined as a patient of this office who has not been treated in this office for 6 months.

Welcome to Our Office!

Name_____ Today's date _____SS# _____
Address _____ City _____ Zip _____
Home phone_____ Age _____ Birth Date _____Marital: M S W D
Employer _____ Address _____ Office phone _____
Name of spouse _____ Spouses employer phone # or address _____
Name of nearest relative _____ address _____phone# _____
Who is your family medical doctor? _____ E-mail:_____
What medications are you taking now?_____ _____
If you are a new patient to our office, whom may we thank for referring you? _____

1. What symptoms or complaint do you continue to experience? _____

2. FREQUENCY of your Complaint, percent of the time:
Rare = less than 10% of the time
Occasional = 10 - 25%
Intermittent = 25-50%
Frequently = 50-75%
Constant = 75-100%

3. SEVERITY:
Minor = only a nuisance
Mild = difficult to live with
Moderate = very difficult to live with
Severe= extremely difficult to live with

4. QUALITY: How would you describe your symptoms?
pain, dull ache, sharp, stabbing, burning, throbbing, tingling, numbness, other: _____

5. Do your symptoms **radiate** down your arm or leg? NO / YES

6.What activities **aggravate** your symptoms? drive, work, etc... _____

7. What gives r**elief**?
Rest, ice, heat, sleep, medication? _____exercise, chiropractic, physical therapy, other:_____

8. Circle the # that corresponds to your symptoms: no symptom = **0 1 2 3 4 5 6 7 8 9 10** = severe symptoms/pain

Place a check next to the activity that hurts or are difficult to perform because of the condition that brought you here:

Personal Grooming:
_____ combing hair
_____ shaving
_____ in / out to bath tub
_____ brushing teeth

Housework:
_____ laundry
_____ making beds
_____ vacuuming
_____ washing dishes
_____ ironing
_____ carrying groceries
_____ caring for pets
_____ cooking

Travel:
_____ driving
_____ passenger: car, train, plane
_____ minutes per day in vehicle
_____ getting in and out of vehicle

Yard Work:
_____ mowing lawn
_____ shoveling: snow, dirt, mulch, sand
_____ raking leaves
_____ gardening

General:
_____ walking
_____ standing
_____ running
_____ sitting

General:
_____ lifting / playing w/children
_____ bending, squatting, stooping
_____ kneeling
_____ climbing stairs
_____ reading
_____ sleeping or lying in bed
_____ rolling over in bed
_____ sports:
_____ hobby:
_____ computer / desk work
_____ using telephone
_____ exercising
_____ OTHER_____

_____ / 36 (37 w/other): This patient has pain or difficulty performing _____% of 36 (37) common ADL's.

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Biopsychosocial

Social :

1. What is your occupation?
2. Have you lost work because of this condition? ___ If yes, how many days or what dates? _____
3. Is this condition due to injury or sickness arising out of employment? _____ auto accident? ___ other?__
4. Do you exercises? If so, where and what type:
5. Do you smoke? no / yes packs / day? _____ No. of years? _____
6. Do you drink alcohol? heavy moderate light times per week_____
7. Do you have small children: no / yes how many?_____
8. Have you ever been in an auto accident? _____ When?_____
9. Have you ever seriously injured yourself from a fall or other trauma? _____
10. What operations have you had and when? _____
11. Serious illness and when? _____

How do you sleep,? on your stomach, half stomach half side with one knee up, back, or side?
Do you sit at a desk frequently? Yes / No
Does your back hurt when you vacuum? Yes / No
Do you drive more than 20 minutes per day on the high way? Yes / No
Do you have to lift or reach for items (any items) on a daily basis? Yes / No

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REVIEW OF SYSTEMS: *Please explain any "YES" answers*

Do you have or have you had significant problems with (your):

1. Eyes, ears, nose or mouth? no / yes _____
2. Heart or lungs? no / yes _____
3. Stomach, digestion (heart burn, indigestion), bowels, bowel movement or gastrointestinal tract? no / yes _____
4. Genitourinary system: please circle symptoms or conditions you now have or have in the past:
   Female: fibroids, breast pain, cancer, PMS, pain associated with period, frequent yeast infections, _____
   Male: urinary difficulties, difficulty stopping or starting urination, prostate enlargement, cancer etc? _____
5. Muscles, ligaments, bones, arthritis, ...? no / yes _____
6. Nerves, i.e. MS, pinched nerve, shaking, tripping, unsteady walk....? no / yes _____
7. Skin , sores, wound care, ...? no / yes _____
8. Psychiatric, i.e. bipolar, frequent depression,.....? no / yes _____
9. Do you seek professional counseling? no / yes _____
10. Is stress a factor in your life?_____
11. Hormones issues, lupus, autoimmune conditions, diabetes? _____
12. Blood or lymphatic problems? no / yes _____
13. Are you currently loosing weight for unknown reasons? no / yes _____
14. Do you have allergies or sensitivities to anything? no / yes _____
15. Other?_____

Family History:

1. Are there health related conditions that run or may run in your family, i.e. back problems, heart disease, cancer, alcohol, etc.. ? no / yes
2. Does or did your mother, father or siblings have allergies or sensitivities?