Welcome to Upston Chiropractic Wellness

Case History

Case # _____ Date _____

Name _____ Date of Birth _____

Telephone # (Home) _____ (Work)_____ (Cell)_____

Address_____ City/State/ZIP_____

Occupation_____ Employer_____

Insurance Co. _____ Social Security # _____ Email: _____

Marital Status: ☐ **S**; ☐ **M**; ☐ **D**; ☐ **W** Spouse's Name _____ # of Children____

Spouse's Insurance Co. _____

Past Chiropractic Care? ☐ **Yes**; ☐ **No** When? _____ Doctor's Name _____

Medical Doctor's Name _____ Last Visit _____

What brings you in today?_____

Are your present symptoms due to any of the following?

☐ auto accident ☐ work injury ☐ an accident ☐ a trauma ☐ an illness

☐ an aggravating of a congenital problem ☐ unknown factors

Date of symptom first appeared _____Have you ever experienced this before?_____

Are you in need of any community resources? ☐ **Yes**; ☐ **No** _____

Do you feel safe? ☐ **Yes**; ☐ **No** _____

Are you currently in an auto accident/work comp case? ☐ **Yes**; ☐ **No** _____

Are you now, or have you ever been, disabled? (Service or work) ☐ **Yes**; ☐ **No**

If yes, when _____ How _____

Referred to us by: _____

Please check any and all of the following conditions that pertain to you. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

_____ Decreased Activity Level
_____ Fever
_____ Chills
_____ Fatigue
_____ Night Sweats
_____ Loss of Appetite
_____ Weight Loss
_____ Weight Gain
_____ Loss of Energy
_____ Uncontrolled Sweating

Mental Health Problems

_____Irritability
_____Depression
_____Disturbed Sleep
_____Suicidal Thoughts
_____ Anxiety
_____ Nervousness

Trouble Urinating?

_____ Frequent Urination
_____ Urgency
_____ Trouble with Stream
_____ Erectile Dysfunction
_____ Nocturia
_____ Burning w/ Urination
_____ Losing Control
_____ Bowel Dysfunction
_____ Sexual Dysfunction

Trouble with Vision

_____ Blurred Vision
_____ Double Vision
_____ Vision Loss
_____ Eye Pain
_____ Glasses/Contacts

Heart Troubles

_____ Chest Pain
_____ Palpitations
_____ Fainting
_____ Shortness of Breath
_____ Ankle Swelling

Breathing Troubles

_____ Coughing
_____ Wheezing
_____ Shortness of Breath

Stomach Problems

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Loss of Bowel Control

Muscle/Joint Problem

_____ Joint Pain
_____ Joint Weakness
_____ Muscle Weakness

Skin Problems

_____ Rash
_____ Itching
_____ Dryness
_____ Lesions
_____ Infections
_____ Hair/Nail Changes

Immunity Problems

_____ Enlarged Lymph Nodes

Endocrine Problems

_____ Diabetes

Neurological Problems

_____ Seizures

_____ Hives _____ Thyroid Disorder _____ Loss of Feeling
_____ Hay Fever _____ Loss of Memory
_____ Persistent Infections

Bleeding Problems

_____ History of Anemia _____ Abnormal Bleeding _____ Bruising
_____ Heat Intolerance _____ Cold Intolerance

Medications

Check all of the following medications that you are currently taking:

_____ Anti-Inflammatories _____ Sleeping Aides _____ Narcotic Pain Relievers
_____ Acetamionphen _____ Anti-Anxiety Meds _____ Anti-Depressants
_____ Muscle Relaxants _____ Medicated Patches _____ Anticonvulsants
_____ Other Medications

Please List the medications and Doses on the line below:

_____
_____
_____
_____

Surgeries

Check all of the types of surgeries that you have had in the past:

_____ Lumbar Fusion _____ Lumbar Laminectomy/Decompression
_____ Posterior Cervical Surgery _____ Anterior Cervical Surgery
_____ Left Hip Surgery _____ Right Hip Surgery
_____ Left Shoulder Surgery _____ Right Shoulder Surgery
_____ Other Surgeries

Please List past Surgeries and their Dates on the line below:

_____
_____
_____
_____

Please indicate your pain level today on a scale from 0-10 (0 being no pain at all and 10 being excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Past History

Check on all past and present medical health problems that you may have.

_____ Diabetes	_____ Lung Disease	_____ Stomach Problems	_____ Ulcer Disease
_____Kidney Disease	_____ Heart Defects	_____ High Cholesterol	_____ Liver Problems
_____ Asthma	_____ Bleed Easily	_____ Arthritis	_____ Other Explain

_____

_____

Family and Social History

Indicate if your parents, sisters or brothers have any of the following problems: (M=Mother, F= Father, B= Brother, S= Sister)

_____ Arthritis	_____ High Blood Pressure	_____ High Cholesterol
_____ Diabetes	_____ Depression	_____ Heart Disease
_____ Cancer	_____ Chronic Pain	_____ Other

Please explain below if the answer is other:

_____

_____

Are you working?

☐ **Yes** ☐ **No**

What Best Describes your type of Work? (select the best answer)

☐ **Retired** ☐ **Not Employed**

☐ **Sedentary Duty** (Occasional Lifting/carrying small items 10 lbs max)

☐ **Light Duty** (Frequent Lifting 20 lbs max; significant walking/standing)

☐ **Medium Duty** (Lifting 50 lbs max; Walking lots)

☐ **Heavy Duty** (Lifting 100 lbs max with frequent lifting and walking)

☐ **Very Heavy Duty** (Lifting Objects heavier than 100 lbs)

Do you drink alcohol?

☐ **Never** ☐ **Occasionally** ☐ **Socially** ☐ **Frequently** (more than 3 days per week)

Have you had substance abuse treatment?

☐ **Yes** ☐ **No**

Have you ever used Illegal drugs? (marijuana, cocaine, etc)

☐ **Yes** ☐ **No**

Have you ever smoked or used tobacco products?

☐ **Yes, currently** ☐ **Yes, past** ☐ **No** **How many per day?**

_____

What is your educational level?

☐ Not completed high school ☐ High school graduate ☐ GED diploma or equivalent

☐ Completed trade school ☐ An associate's degree ☐ Completed business school

☐ A bachelor's degree ☐ A master's degree ☐ Completed medical school

☐ Completed law school ☐ a Ph.D.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only.

Patients Signature X_____ Date _____

Guardian or Spouse's

Signature authorizing Care _____ Date _____