Chiropractic Health Innovations

EXAM
PATIENT HISTORY

Incident: PI WC Group Cash MC

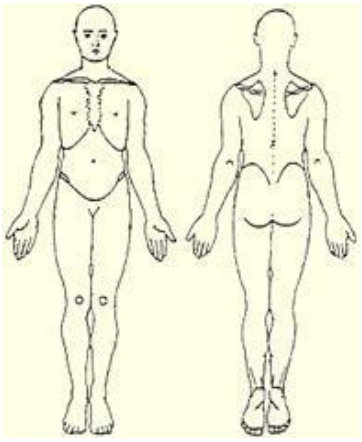
Insurance:_____

_____
Today's Date (MM/DD/YYYY)

_____ _____ _____
Last Name First Name Middle Name (Initial)

1. **What symptoms prompted you to seek care today?**_____

2. **When did these symptoms start? How did they start?**_____



3. **Quality of Symptoms**(What does it feel like?)
- ◯ Numbness
- ◯ Tingling
- ◯ Tightness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Heavy
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other

4. **Intensity** (How extreme symptoms)
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Absent Uncomfortable Agonizing

5. **Duration & Timing** (how often do you feel it?)
◯Constant ◯ Comes and goes

6. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)
_____

7. **Aggravating or Relieving Factors** (What make it better or worse, such as time of day, movements, activities, etc.)
What tends to lessen the problem?_____
What tends to worsen the problem? _____

8. **Prior Interventions** (What have you done to relieve the symptoms?)
- ◯ Prescription medication
- ◯ Over-the-counter drugs
- ◯ Chiropractic
- ◯ Ice
- ◯ Heat
- Other_____

9. What else should we know about your current condition?_____
_____
_____

10. Review of systems (**UNDERLINE** ANY CONDITIONS PAST OR PRESENT)

		Current	Past	None
a.	**Musculoskeletal System-**osteoporosis, arthritis, neck pain, back problems, poor posture	◯	◯	◯
b.	**Neurological System-**anxiety, depression, headache, dizziness, pins & needles, numbness	◯	◯	◯
c.	**Cardiovascular System**-high blood pressure, low blood pressure, high cholesterol, chest pain	◯	◯	◯
d.	**Integumentary System**-skin cancer, psoriasis, eczema, acne, hair loss, rash	◯	◯	◯
e.	**Genitourinary System**-kidney stones, infertility, bedwetting, prostate issues, PMS symptoms	◯	◯	◯
f.	**Constitutional System**-fainting, low libido, poor appetite, fatigue, sudden weight, weakness	◯	◯	◯
g.	**Lymphatic System**-swelling or pain in lymph nodes of neck, axillae, groin & other areas	◯	◯	◯

11. Prior illnesses, operation, injuries or treatments:_____
_____
_____

12. **Social History** (Tell us about your health habits)
Allergies:_____
Tobacco Use:_____

13. Medications/Supplements:_____
_____

14. Goals/Problems_____
_____

POC

NOTE

CODES

CHARGES