McALPINE
CHIROPRACTIC GROUP

Initial Case History

Today's Date: _____

Patient Title: ❒ Mr. ❒ Mrs. ❒ Ms. ❒ Dr. Name: _____ Age: _____

Email: _____ DOB: _____ Gender: _____

Cell Phone & Provider (for appt messaging): _____ Home Phone: _____

Address: _____ City/State: _____ Zip: _____

Primary Care Physician: _____ Occupation: _____

Race: ❒ American Indian ❒ African American ❒ Asian ❒ Caucasian ❒ Pacific Islander ❒ I choose not to specify

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Other: _____ ❒ I choose not to specify

Marital Status: ❒ Single ❒ Married Number of Children: _____ Referred By: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

PRIMARY REASON FOR CONSULTING OUR OFFICE

Primary Complaint Today: _____

This problem started: ❒ Gradually ❒ Suddenly **When did it start bothering you?** _____

This condition is: ❒ Constant (>75%) ❒ Frequent (50-75%) ❒ Intermittent (25-50%) ❒ Comes and goes (<25%)

This condition is getting: ❒ Better ❒ Worse ❒ Staying the same

Cause of complaint: _____

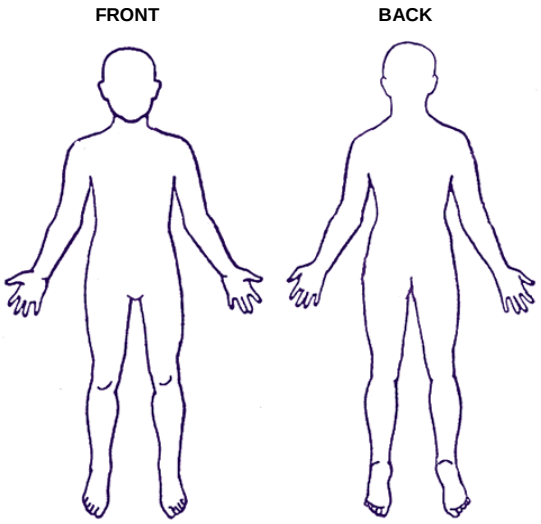
What makes the problem worse?

❒ Standing ❒ Sitting ❒ Twisting ❒ Bending
❒ Lifting ❒ Lying ❒ Other _____

Is there anything you can do to relieve the problem?

❒ Sleeping ❒ Standing ❒ Rest ❒ Other _____
❒ Medication ❒ Ice/Heat ❒ Nothing

Indicate where you have **ANY** pain/symptoms.



Describe the pain:

❒ Aching ❒ Burning ❒ Cramping ❒ Deep
❒ Dull ❒ Soreness ❒ Radiating ❒ Sharp
❒ Tightness ❒ Throbbing ❒ Shooting ❒ Stabbing
❒ Stiff ❒ Numbness/Tingling

How would you rate your condition today on a scale of 0 (no pain) to 10 (worst possible)?

No Pain = 0 1 2 3 4 5 6 7 8 9 10 = **Worst Possible**

Is your condition worse at certain times of the day? ❒ Morning ❒ Afternoon ❒ Evening ❒ During sleep

OTHER REASONS FOR CONSULTING OUR OFFICE

Do You Have Any Additional Health Complaints Today? Please list below (ex. stress, weight, nutrition, etc.)

_____

_____

FAMILY HISTORY

Please list diagnosed health conditions or untimely deaths for family (parents, siblings, grandparents, aunts/uncles).

ALLERGY HISTORY

Please list any known allergies or reactions of any kind (including food, medication and/or environmental):

REVIEW OF SYMPTOMS

Please mark all that apply. Check None if not applicable to you.

Constitutional	❒ None	❒ daytime drowsiness	❒ fever	❒ night sweats
	❒ chills	❒ fatigue	❒ loss of appetite	❒ weight gain /loss
Eyes/Vision	❒ None	❒ cataracts	❒ itching	❒ wears contacts/glasses
	❒ blindness	❒ double vision	❒ light sensitivity	❒ blind spots
Ears, Nose & Throat	❒ None	❒ fainting	❒ history of head injury	❒ runny nose
	❒ dizziness	❒ frequent sore throat	❒ loss of smell	❒ sinus infection
	❒ ear discharge	❒ headaches	❒ nosebleeds	❒ ringing in ears
	❒ ear pain	❒ hearing loss	❒ nasal congestion	❒ allergies
Respiratory	❒ None	❒ cough	❒ shortness of breath	❒ wheezing
	❒ asthma	❒ coughing up blood	❒ sputum production	
Cardiovascular	❒ None	❒ high blood pressure	❒ heart murmur	❒ leg pain and ache when walking
	❒ fainting	❒ low blood pressure	❒ palpitations	❒ shortness of breath with exertion
	❒ heart problem	❒ chest pain	❒ cold hands/feet	❒ difficulty breathing lying down
Gastrointestinal	❒ None	❒ belching	❒ difficulty swallowing	❒ jaundice
	❒ abdominal pain	❒ black tarry stool	❒ heartburn	❒ ulcers
	❒ diarrhea	❒ constipation	❒ hemorrhoids	❒ rectal bleeding
	❒ indigestion	❒ loss of bowel control	❒ abnormal stool color/consistency	
Female	❒ None	❒ birth control	❒ frequent urination	❒ vaginal discharge
	❒ breast lump	❒ burning urination	❒ cramps	❒ urine retention/incontinence
	❒ breast pain	❒ hormone therapy	❒ irregular menstruation	❒ abnormal vaginal bleeding
Male	❒ None	❒ burning urination	❒ frequent urination	❒ urine retention/incontinence
	❒ prostate problem	❒ hesitancy/dribbling	❒ erectile dysfunction	
Skin	❒ None	❒ change in skin color	❒ rash	❒ history of skin disorders
	❒ hair loss	❒ hives	❒ itching	❒ change in nail texture
	❒ numbness	❒ varicose veins	❒ eczema	
Nervous System	❒ None	❒ limb weakness	❒ seizures	❒ loss of consciousness
	❒ dizziness	❒ slurred speech	❒ sleep disturbance	❒ loss of balance
	❒ facial weakness	❒ stroke	❒ loss of taste	❒ loss of memory
	❒ headache	❒ numbness	❒ difficulty falling asleep	❒ migraine
Psychological	❒ None	❒ bi-polar disorder	❒ depression	❒ memory loss
	❒ ADD/ADHD	❒ convulsions	❒ mood change	❒ loss or change of appetite
	❒ anxiety	❒ confusion	❒ insomnia	❒ behavioral change
Hematologic	❒ None	❒ bleeding	❒ blood transfusion	❒ lymph node swelling
	❒ anemia	❒ blood clotting	❒ bruise easily	

ACTIVITIES OF DAILY LIVING

In the past 30 days, has PAIN or LACK OF FUNCTIONAL ABILITY (mobility, balance, strength) limited your ability to:

Read: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Sit: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Sleep: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Stand: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Work: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Walk: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Grooming/Dressing: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Concentrate: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Social Activities: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Lift Heavy Objects: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Operate a Vehicle: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

Recreation: ❒ Never ❒ Seldom ❒ Sometimes ❒ Often ❒ Always

MEDICATION/SUPPLEMENTATION HISTORY

Are you taking any medications or supplements? (please include regularly used over the counter medications)

_____

_____

WOMEN ONLY

Are you pregnant? ❒ No ❒Yes, Number of weeks _____ ***and*** Estimated due date _____

PERSONAL INCIDENT/INJURY HISTORY

Have you ever experienced any of the following? If yes, please include date and fully explain:

Broken a bone: ❒ No ❒ Yes, _____

Been knocked unconscious: ❒ No ❒ Yes, _____

Had a stroke: ❒ No ❒ Yes, _____

Had major sprain/strains: ❒ No ❒ Yes, _____

Had a surgery: ❒ No ❒ Yes, _____

Been in a car accident: ❒ No ❒ Yes, _____

Been hospitalized: ❒ No ❒ Yes, _____

SOCIAL/DIET HISTORY

Mental Stress: ❒ Mild ❒ Moderate ❒ Severe

Aerobic Exercise: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Resistance Exercise: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Omega-3 Supplement: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Vitamin D Supplement: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Fast/Processed Food: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Fresh/Homemade Foods: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Alcohol: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Soft Drinks: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Caffeine Products: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Drugs: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

Tobacco: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Never

How many ounces of water do you drink on average in a day? (8 ounces = one cup)

_____

How many hours a day do you spend sitting?

_____

PATIENT SIGNATURE: _____ **DATE:** _____