INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

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

Home: (_____)_____-_____ **Mobile:** (_____)_____-_____ **Work:** (_____)_____-_____

Email: _____ G**ender:** M / F **Marital Status:** Single / Married / Other

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

Student Status: Full Time Student / Part Time Student / Non-Student **Employed:** Y / N

Ethnicity: Hispanic or Latino / Not Hispanic or Latina / Decline **Preferred Language:** English / Other: _____

Race: Asian / African American / American Indian / White / Decline / Other: _____

***Referred By:** *(Name)* _____

Family / Friend / Co-Worker / Doctor / Another Source: _____

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: (_____)_____-_____ **Mobile:** (_____)_____-_____ **Doctor's Phone Number:** (_____)_____-_____

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION / RESPONSIBLE PARTY

Who is responsible for payment? Self / Other: *(Relationship)* _____

If Other than Self:

Name: *(First MI Last)* _____

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

Phone: (_____)_____-_____ **Email:** _____

*Please initial below you are aware that **Dynamic Life** is a CASH ONLY office and can accept payment in the form of:*
Cash, Check, most Credit Cards (Visa/Mastercard/American Express/Discover)
and most Contactless (Apple Pay, Samsung Pay, Google Pay)

(Initials) _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged.

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe Any Secondary Complaints: _____

Describe WHEN and HOW this began: _____

_____

Grade Intensity/Severity: None *(0)* / Mild *(1-2)* / Mild-Mod *(2-4)* / Moderate *(4-6)* / Mod-Severe *(6-8)* / Severe *(8-10)*

Quality of the Complaint/Pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How Frequent is the Complaint Present: Off & On / Constant

Does this Complaint Radiate/Shoot to any areas of your body? No / Yes *(Describe)* _____

Head – Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* – Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area*: _____

Does anything make the Complaint Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the Complaint Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

What Daily Activities are being affected by this Condition? *(Describe)* _____

For this CURRENT Condition, have you:

Received ANY Other Treatment Elsewhere? None / Yes *(Where?)* _____

Had any Diagnostic Testing? X-rays / MRI / CT / Other: _____ When / Where? _____

HEALTH HISTORY

Medications and Supplements:

Allergies to Medications: ***NONE***

Name	Reaction

Current Medications & Supplements: ***NONE***

Name	Dosage	Frequency	Method

Past Health History: *(Please list any past…)*

Number of Falls in last 24 months: _____ **Injuries?** Y / N

Surgeries: ***NONE***

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: ***NONE***

Date	Describe

Family Health History: *N/A*

List *relevant* major health problems of immediate relatives:

Problem	Parent *(M or F)*	Sibling *(B or S)*	Child *(S or D)*

Social and Occupational History:

Smoking/Tobacco Use:

Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education:

High School / College Grad / Post Grad / Other: _____

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

REVIEW OF SYSTEMS

Are you *CURRENTLY* experiencing any of these symptoms? *(Check all that apply)*

Many of the following conditions respond to Chiropractic treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *NONE in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones _____
- ☐ Other: _____
- ☐ *NONE in this Category*

Neurological:
- ☐ Numbness or Tingling Sensations
- ☐ Loss of Feeling
- ☐ Dizziness or Light-Headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: _____
- ☐ *NONE in this Category*

Mind & Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *NONE in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in Force/Strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *NONE in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausia or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *NONE in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat Changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *NONE in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *NONE in this Category*

Eyes & Vision:
- ☐ Wear Contacts/Glasses
- ☐ Blurred or Double Vision
- ☐ Glaucoma
- ☐ Eye Disease or Injury
- ☐ Other: _____
- ☐ *NONE in this Category*

Ears, Nose & Throat:
- ☐ Bleeding Gums / Mouth Sores
- ☐ Bad Breath or Bad Taste
- ☐ Dental Problems
- ☐ Swollen Throat or Voice Change
- ☐ Swollen Glands in Neck
- ☐ Ringing in the Ears
- ☐ Ear Ache/Drainage
- ☐ Sinus/Allergy Problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ *NONE in this Category*

Endocrine, Hematologic & Lymphatic:
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Head or Cold Intolerance
- ☐ Change in Hat or Glove Size
- ☐ Dry Skin
- ☐ Glandular or Hormone Problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune System Disorder
- ☐ Other: _____
- ☐ *NONE in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in Hair or Nails
- ☐ Non-Healing Sores
- ☐ Change in Appearance of a Mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *NONE in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes** – *Due Date* ____/____/_____
- ☐ **No** – *Last Menstrual Period* ____/____/_____
- ☐ Infertility
- ☐ Painful or Irregular Periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *NONE in this Category*

Pregnancies:

Date	Outcome

Comments: _____

_____

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize **Dynamic Life** to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.*

Patient or Guardian Signature: _____ Date: _____

Doctor Beatty's Signature: _____ Date: _____

Patient No: *(Office Use)* _____ Doctor's Initials: _____