

FOWLER CHIROPRACTIC PATIENT CASE HISTORY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Telephone: (H) _____ (Cell) _____ (W) _____

Email: _____ Occupation: _____

Gender: Male Female Circle if you are Married Single Widowed Divorced

Where are you Employed? _____ Referred By: _____

Person Responsible for this Account: _____ Health Plan: _____

Subscribers Name: _____ ID# _____ GRP# _____

Surgeries:

1. _____ Date: _____

2. _____ Date: _____

Circle Any **Allergies:**

Animals Bees Chocolate Dairy Dust Eggs Latex Molds Ragweed/Pollen Shellfish

Seasonal Allergies Soaps Wheat X-Ray Dye Other: _____

Circle Any **Allergies to Medicine:**

Advil Amoxicillin Codeine Demerol Erythromycin Hydrocodone Morphine Penicillin

Percocet Sulfa Tylenol Vicodin Other: _____

Current Medication:

Name

Reason

1. _____

2. _____

3. _____

4. _____

5. _____

Patient Health Questionnaire

Patient Name: _____ Date: _____

Please check if you have ever had a symptom listed below.

Past	Present		Past	Present
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain		Shoulder Pain L__R __
		Upper Back		Lower Back L__ R __
		Jaw L__ R__		Hip/Leg L__ R__
		Dizziness		Ringing in Ears
		Sciatica L__R__		Depression
		Arm L__ R__		Elbow L__R__
		Hand L__R__		Headaches
		Arthritis		Asthma
		Broken Bones		Chest Pain
		Diabetes		Epilepsy
		Eye/Vision		Fainting
		Fatigue		Joint Stiffness
		High Blood Pressure		Knee L__ R__
		Heart Problems		Multiple Sclerosis
		RA		Neurological
		Pacemaker		Parkinson's
		Polio		Prostate Problems
		Spinal Cord Injury		Sprain/Strain
		Stroke/Heart Attack		Other _____

HISTORY OF PRESENT ILLNESS

Major Complaint _____

Secondary Complaint (if applicable) _____

Date Problem Began ____/____/____

Date Problem Began ____/____/____

How? _____

How? _____

How is your condition changing? Better Worse Same Past/Previous Condition? Y N

Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

Describe nature of symptoms

- Sharp Dull Tight Numb
- Burning Shooting Tingling
- Stabbing Throbbing
- Radiating Pain
- Other _____

Rate your pain on a scale of 1 to 10 (0= No pain and 10= Excruciating Pain).

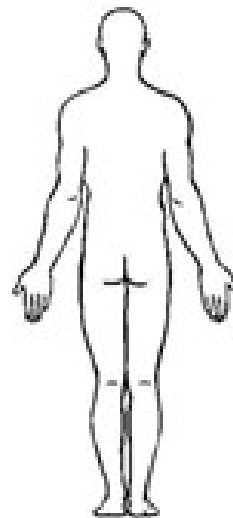
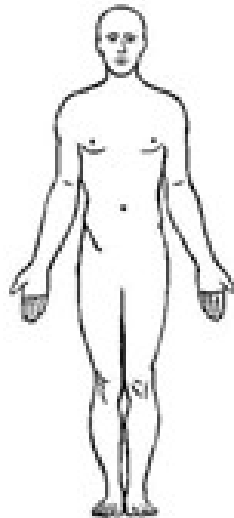
1 2 3 4 5 6 7 8 9 10 Mild Moderate Severe

How often do you experience your symptoms? (Circle One)

Constantly (80-100%) Frequently (25-80%) Occasionally (0-25%)

What activities aggravate your condition? (working, exercise, etc.): _____

What makes your pain better? (ice, heat, massage, etc.): _____



Signature

Date