

## Westlake Chiropractic Case History

Name \_\_\_\_\_ I like to be called \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  It's OK to receive texts from this office

DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex  M  F Marital Status  Single  Married  Widowed  Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Email \_\_\_\_\_  It's OK to receive email reminders and notifications from this office

It's  OK  not OK for medical information (insurance claim forms, etc.) to be emailed by this office

How did you hear about us?  Referred by \_\_\_\_\_  Other \_\_\_\_\_

### 1. Reason(s) for seeking chiropractic care:

Primary reason (Chief Complaint): \_\_\_\_\_

Secondary reason: \_\_\_\_\_

Other factors contributing to the primary and secondary reasons: \_\_\_\_\_

### 2. Chief complaint:

Location of complaint: \_\_\_\_\_

Complaint began when and how? \_\_\_\_\_

Please check the quality of the complaint's pain:  dull  aching  sharp  shooting  burning  throbbing  stiff  sore  other \_\_\_\_\_

Does this complaint's pain radiate or travel (shoot) to any areas of your body?  Y  N Where? \_\_\_\_\_

Do you have any numbness or tingling in your body?  Y  N Where? \_\_\_\_\_

Please rate your complaint's pain intensity (0 = No pain, 10 = Worst possible pain) 0 1 2 3 4 5 6 7 8 9 10

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything make the complaint worse? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

### 3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

\_\_\_\_\_

\_\_\_\_\_ Do you wear a heel lift?  Y  N

### 4. Past health history:

Previous accidents, injuries, broken bones (with approximate date, use back of the sheet if necessary): \_\_\_\_\_

\_\_\_\_\_

Hospitalizations, operations, procedures, major illnesses or diseases (with approximate date, use back of the sheet if necessary): \_\_\_\_\_

\_\_\_\_\_

Drugs, herbs, supplements (use back of the sheet if necessary): \_\_\_\_\_

\_\_\_\_\_

Allergies (list if mild or severe): \_\_\_\_\_

\_\_\_\_\_

Females - are you pregnant?  Y  N What was the date of the beginning of your last menstrual period? \_\_\_\_\_

**5. Family health history:**

Associated health problems of immediate family (such as diabetes, cancer, high blood pressure): \_\_\_\_\_  
\_\_\_\_\_

Cause of death in parent or sibling and their age: \_\_\_\_\_

**6. Social and occupational history:**

Level of education:  High school  Trade School  College  Post graduate

Job description and work schedule: \_\_\_\_\_

Recreational activities/hobbies: \_\_\_\_\_

Lifestyle (level of exercise, alcohol, tobacco and drug use, diet): \_\_\_\_\_  
\_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize the office of Westlake Chiropractic to provide me with chiropractic care in accordance with the statues of the state of Texas.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Functional Rating Index**

Please circle the number which most closely describes your condition right now.

**Pain Intensity:**

0 - No pain                      1 - Mild pain                      2 - Moderate pain                      3 - Severe pain                      4 - Worst possible pain

**Sleeping:**

0 - Perfect sleep                      1 - Mildly disturbed                      2 - Moderately disturbed                      3 - Greatly disturbed                      4 - Totally disturbed

**Personal Care (washing, dressing, etc.):**

0 - No pain no restrictions                      1 - Mild pain no restrictions                      2 - Moderate pain must go slowly                      3 - Moderate pain need assistance                      4 - Severe pain 100% assistance

**Travel (driving, etc.):**

0 - No pain long trips                      1 - Mild pain long trips                      2 - Moderate pain on long trips                      3 - Moderate pain on short trips                      4 - Severe pain short trips

**Work:**

0 - Usual work + extra                      1 - Usual work, no extra                      2 - 50% of usual work                      3 - 25% of usual work                      4 - Cannot work

**Recreation:**

0 - All activities                      1 - Most activities                      2 - Some activities                      3 - Few activities                      4 - No activities

**Frequency of Pain:**

0 - No pain                      1 - Occasional (25%)                      2 - Intermittent (50%)                      3 - Frequent (75%)                      4 - Constant (100%)

**Lifting:**

0 - No pain with heavy lifting                      1 - Increased pain with heavy lifting                      2 - Increased pain moderate lifting                      3 - Increased pain light lifting                      4 - Increased pain with any lifting

**Walking:**

0 - No pain with any distance                      1 - Increased pain after one mile                      2 - Increased pain after one-half mile                      3 - Increased pain after one-quarter mile                      4 - Increased pain any distance

**Standing:**

0 - No pain at any time                      1 - Increased pain after several hours                      2 - Increased pain after one hour                      3 - Increased pain after one-half hour                      4 - Increased pain standing

Total \_\_\_\_\_ /4, X10 = Functional Rating Score \_\_\_\_\_%

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Treating Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_