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 _____ Social Security #_____ 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:

_____

_____

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_____