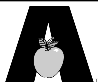
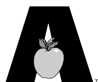


CONFIDENTIAL PATIENT HEALTH RECORD – UPDATED HISTORY OF PRESENT ILLNESS/INJURY

PLEASE PRINT:
NAME: ______________________________ DATE: ______________



HISTORY OF PRESENT ILLNESS/INJURY

PLEASE BE SPECIFIC

CHIEF COMPLAINT

BE SURE TO FILL OUT THIS SECTION AS ACCURATELY AS POSSIBLE. MARK THE AREA WITH THE DESCRIBED SENSATION. USE THE APPROPRIATE SYMBOLS. IF THERE IS MORE THAN ONE AREA OF DISCOMFORT, PLEASE RATE THE PAIN ON A SCALE OF 0 TO 100 NEXT TO EACH AREA, WITH 0 BEING NO PAIN AND 100 BEING INTOLERABLE PAIN.

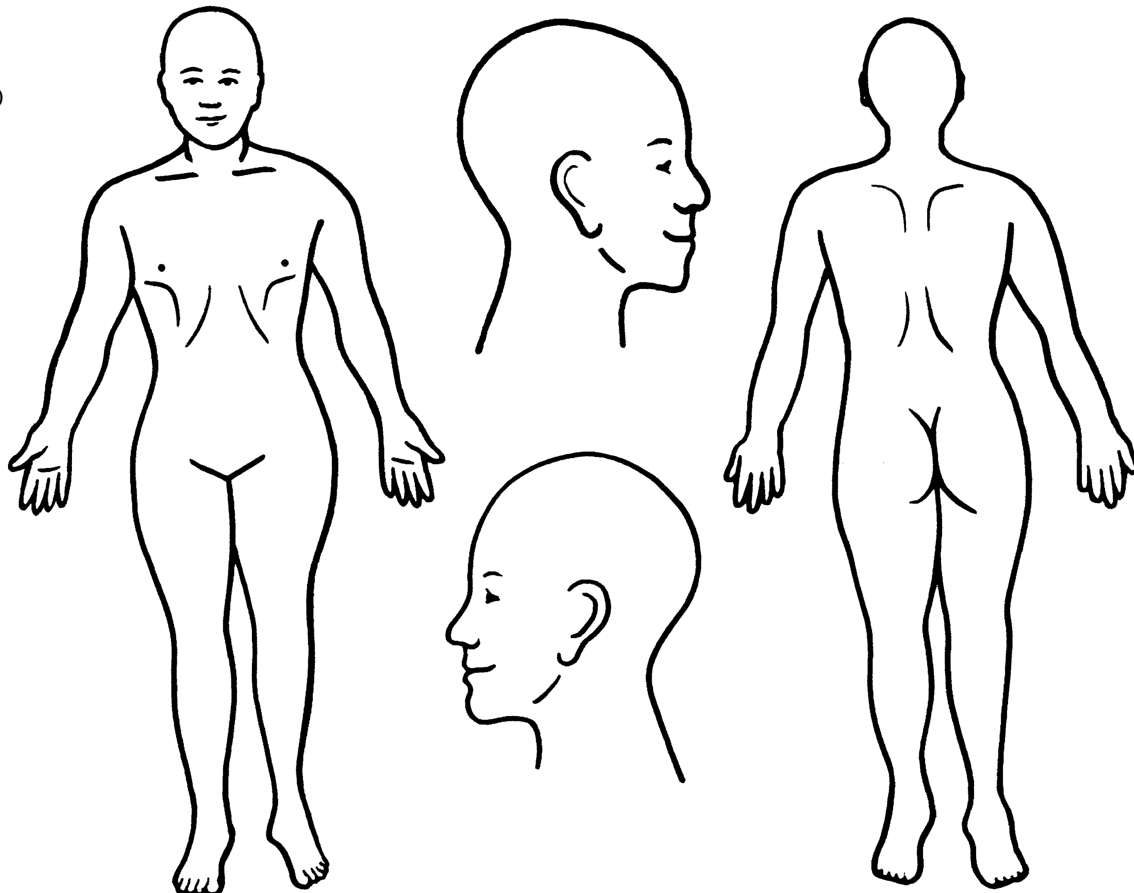
XXX BURNING (BU)
(((ACHING PAIN (AC)
000 PINS & NEEDLES (PI)
- - - NUMBNESS (NU)
: : : SHARP PAINS (SH)

FOR OFFICE USE ONLY:
____ CONSTANT
____ COME/GO

SYMPTOMS HAVE:
____ INCREASED (⇑)
____ DECREASED (⇓)
____ STAYED THE SAME
____ NORMAL (NL)

BETTER:		WORSE:
____	AM	____
____	MIDDAY	____
____	PM	____

% IMPROVEMENT PER AREA



PAIN SCALE:

WHAT MAKES THE CONDITION BETTER?

HEAD NECK ______________
MID BACK ______________
LOW BACK ______________
SHOULDER, ARM, HAND ______________
HIP, LEG, FOOT ______________
OTHER ______________

WHAT MAKES THE CONDITION WORSE?

HEAD NECK ______________
MID BACK ______________
LOW BACK ______________
SHOULDER, ARM, HAND ______________
HIP, LEG, FOOT ______________
OTHER ______________

❑ YES ❑ NO DOES THE PAIN INTERFERE WITH YOUR SLEEP? HOW MANY TIMES DO YOU WAKE UP? ______________

❑ YES ❑ NO DOES WEATHER AFFECT YOUR PAIN? ______________

INDICATE YOUR ABILITY TO PERFORM THE FOLLOWING ACTIVITIES. PLEASE USE THESE CODES:
U - UNABLE L - LIMITED P-PAINFUL D-DIFFICULT N-NORMAL H-HAVEN'T TRIED

1.___ LYING ON BACK
2.___ LYING ON SIDE W/KNEES BENT
3.___ TURNING OVER IN BED
4.___ GETTING IN/OUT OF CAR
5.___ LYING FLAT ON STOMACH
6.___ REACHING
7.___ GRIPPING
8.___ CLIMBING
9.___ PULLING
10.___ DRESSING SELF
11.___ SEXUAL ACTIVITY
12.___ SLEEPING
13.___ PUSHING
14.___ KNEELING
15.___ STOOPING
16.___ SITTING AT TABLE
17.___ BENDING FORWARD
18.___ WALKING SHORT DISTANCES
19.___ BENDING FORWARD TO BRUSH TEETH
20.___ STANDING MORE THAN ONE HOUR
21.___ BALANCING
22.___ COUGH/SNEEZE/GRUNT
HOW? ______________
WHERE? ______________

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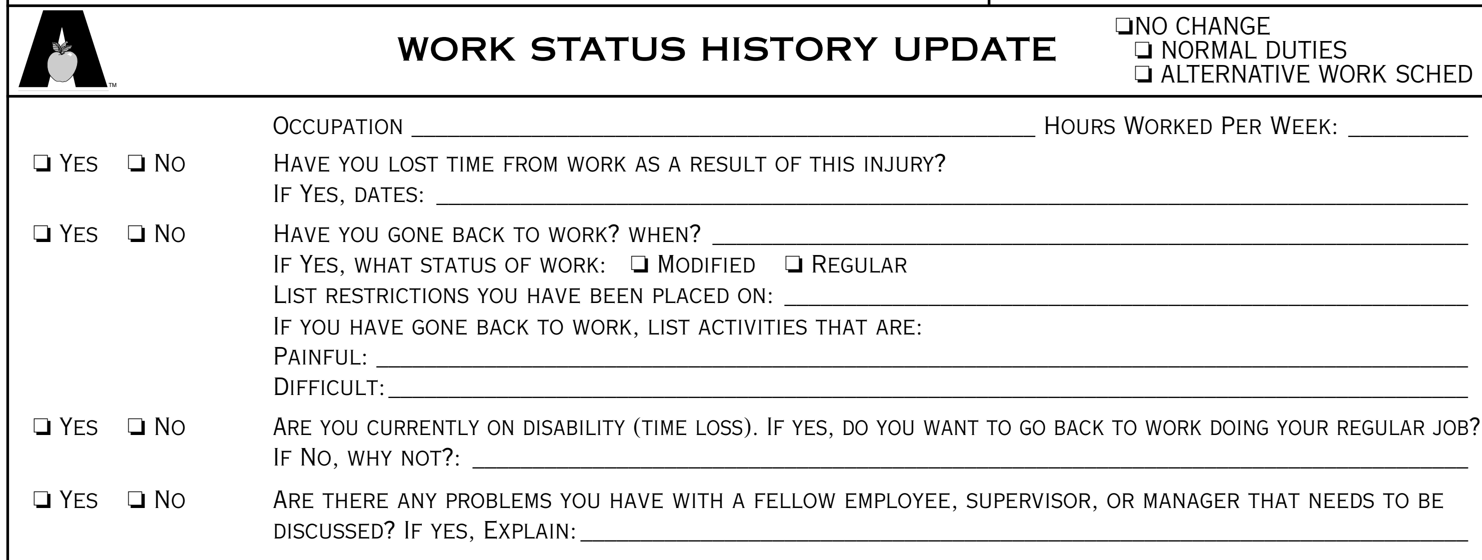
My **Motion** has/is	Increased but not normal	Decreased	Normal
Neck/Upper Back			
Midback/Low back			
Hips/Legs/Feet			
Shoulders/Arms			
Other			

My **Strength** has/is	Increased but not normal	Decreased	Normal
Neck/Uppper Back			
Midback/Low back			
Hips/Legs/Feet			
Shoulders/Arms			
Other			

The **Frequency** of my discomfort has/is	Decreased but not normal	Increased	Normal
Headache	x per ____	x per ____	
Neck/Uppper Back			
Midback/Low back			
Hips/Legs/Feet			
Shoulders/Arms			
Other			

Comments:
____



WORK STATUS HISTORY UPDATE

❏ No change
❏ Normal duties
❏ Alternative work sched

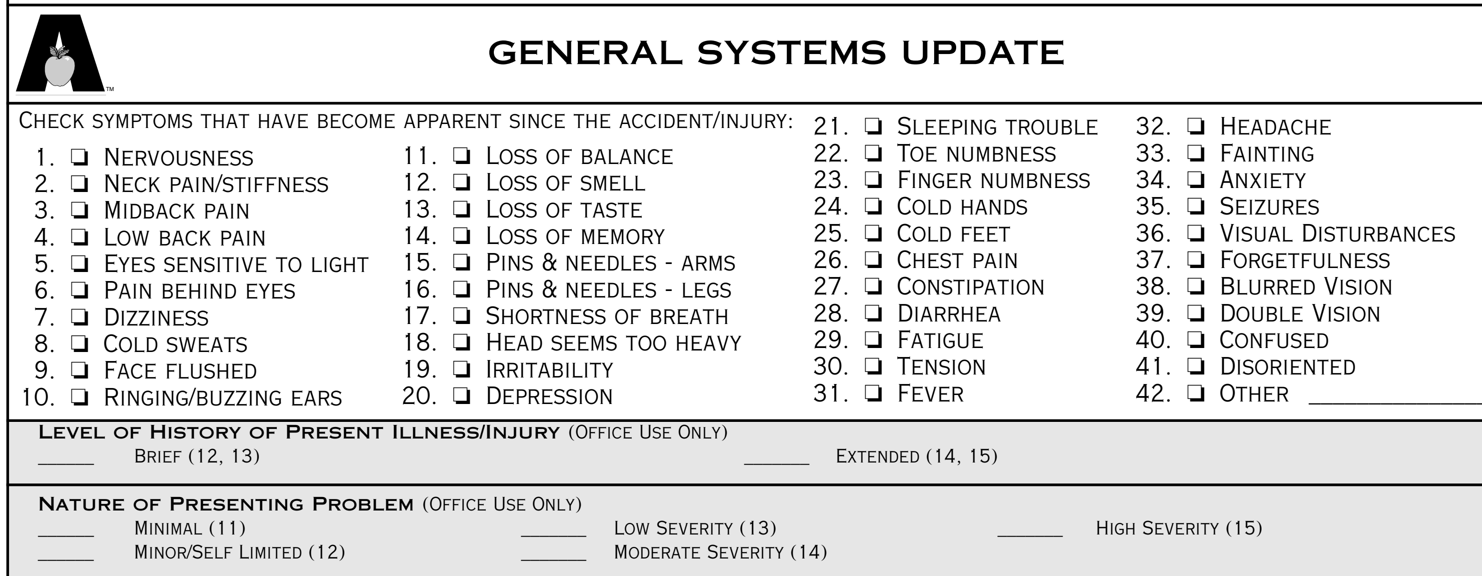
Occupation ______________________ Hours Worked Per Week: ________

❏ Yes ❏ No — Have you lost time from work as a result of this injury?
If Yes, dates: ______________________

❏ Yes ❏ No — Have you gone back to work? when? ______________________
If Yes, what status of work: ❏ Modified ❏ Regular
List restrictions you have been placed on: ______________________
If you have gone back to work, list activities that are:
Painful: ______________________
Difficult: ______________________

❏ Yes ❏ No — Are you currently on disability (time loss). If yes, do you want to go back to work doing your regular job?
If No, why not?: ______________________

❏ Yes ❏ No — Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, Explain: ______________________



GENERAL SYSTEMS UPDATE

Check symptoms that have become apparent since the accident/injury:

1. ❏ Nervousness
2. ❏ Neck pain/stiffness
3. ❏ Midback pain
4. ❏ Low back pain
5. ❏ Eyes sensitive to light
6. ❏ Pain behind eyes
7. ❏ Dizziness
8. ❏ Cold sweats
9. ❏ Face flushed
10. ❏ Ringing/buzzing ears
11. ❏ Loss of balance
12. ❏ Loss of smell
13. ❏ Loss of taste
14. ❏ Loss of memory
15. ❏ Pins & needles - arms
16. ❏ Pins & needles - legs
17. ❏ Shortness of breath
18. ❏ Head seems too heavy
19. ❏ Irritability
20. ❏ Depression
21. ❏ Sleeping trouble
22. ❏ Toe numbness
23. ❏ Finger numbness
24. ❏ Cold hands
25. ❏ Cold feet
26. ❏ Chest pain
27. ❏ Constipation
28. ❏ Diarrhea
29. ❏ Fatigue
30. ❏ Tension
31. ❏ Fever
32. ❏ Headache
33. ❏ Fainting
34. ❏ Anxiety
35. ❏ Seizures
36. ❏ Visual Disturbances
37. ❏ Forgetfulness
38. ❏ Blurred Vision
39. ❏ Double Vision
40. ❏ Confused
41. ❏ Disoriented
42. ❏ Other ____________

Level of History of Present Illness/Injury (Office Use Only)

_____ Brief (12, 13) _____ Extended (14, 15)

Nature of Presenting Problem (Office Use Only)

_____ Minimal (11) _____ Low Severity (13) _____ High Severity (15)
_____ Minor/Self Limited (12) _____ Moderate Severity (14)

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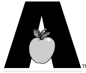

PAST MEDICAL HISTORY UPDATE

❏ NO CHANGE SINCE LAST EVALUATION

❏ YES ❏ NO SINCE YOU BEGAN TREATMENT FOR THIS INJURY/INJURY, HAVE YOU HAD ANY ACCIDENTS, ILLNESSES, INJURIES, FALLS, SURGERIES, OR HOSPITALIZATIONS? IF YES, PLEASE DESCRIBE: ______________________________

____

❏ YES ❏ NO HAVE YOU SEEN ANOTHER HEALTH CARE PROVIDER FOR THIS OR ANY OTHER INJURY OR ILLNESS? IF YES, PLEASE DESCRIBE ______________________________

❏ YES ❏ NO DO YOU NOW TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS?

PRODUCT/DRUG	REASON	FREQUENCY	DOSAGE	HELPING?
1.				
2.				
3.				

SOCIAL HISTORY UPDATE

❏ NO CHANGE SINCE LAST EVALUATION

❏ YES ❏ NO DO YOU SMOKE? PACKS PER DAY? _________

❏ YES ❏ NO DO YOU CONSUME CAFFEINE? HOW MUCH PER DAY? _________

❏ YES ❏ NO DO YOU CONSUME ALCOHOL? HOW MANY GLASSES PER WEEK/DAY? _________

❏ YES ❏ NO HAVE YOU BEEN FOLLOWING THE RECOMMENDATIONS MADE BY THE DOCTOR REGARDING STRETCHING AND EXERCISE? IF NO, WHY NOT? ______________________________

❏ YES ❏ NO ARE YOU ENGAGING IN ANY RECREATIONAL ACTIVITIES? WHAT? ______________________________

❏ YES ❏ NO ARE YOU COMMUTING TO WORK? HOW FAR? ______________________________

FAMILY HEALTH HISTORY UPDATE

❏ NO CHANGE SINCE LAST EVALUATION

❏ YES ❏ NO HAS THERE BEEN ANY CHANGE IN THE HEALTH OF YOUR BLOOD RELATIVES? (MOTHER, FATHER, BROTHERS, SISTERS, CHILDREN) WHAT ______________________________

____

____

____

LEVEL OF PAST MEDICAL, FAMILY, SOCIAL HISTORY (OFFICE USE ONLY)

_____ N/A (11, 12, 13)

_____ PERTINENT (14) *(ONE OF THE ABOVE HISTORIES COMPLETED)*

_____ COMPLETE (15) *(2 OR 3 OF THE ABOVE HISTORIES COMPLETED)*

SYSTEM REVIEW UPDATE

❏ NO CHANGE SINCE LAST EVALUATION

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES OR N FOR NO IN EACH OF THE FOLLOWING:)

1. ____ EYES
2. ____ EARS, NOSE, MOUTH, THROAT
3. ____ HEART
4. ____ LUNGS/BREATHING
5. ____ INTESTINES
6. ____ URINARY
7. ____ MUSCLES
8. ____ NERVES
9. ____ SKIN
10. ____ PSYCHOLOGICAL
11. ____ INTERNAL ORGANS
12. ____ BLOOD
13. ____ ALLERGIES
14. ____ OTHER______________________

____

LEVEL OF SYSTEM REVIEW (OFFICE USE ONLY)

_____ N/A (11, 12)

_____ PROBLEM PERTINENT (13) *(ONE OF THE ABOVE SYSTEMS)*

_____ EXTENDED (14,) *(2 TO 9 OF THE ABOVE SYSTEMS)*

_____ COMPLETE (15) *(10 OR MORE OF THE ABOVE SYSTEMS)*

ADDITIONAL COMMENTS:

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT IS SO APPROVED.

PATIENT SIGNATURE:______________________________ DATE:______________

GUARDIAN SIGNATURE: ______________________________ DATE ______________

D.C./C.A. SIGNATURE: ______________________________ DATE ______________

LEVEL OF HISTORY (OFFICE USE ONLY)

_____ PROBLEM FOCUSED (12)

_____ EXPANDED PROBLEM FOCUSED (13)

_____ DETAILED (14,)

_____ COMPREHENSIVE (15)

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