CONFIDENTIAL CASE HISTORY FILE

Date: ________________________ Full Legal Name: ____

Address: ____ City/State/Zip ________________________

Phone: (home)(_____)____________________(work) (_____) ______________ (cell)(_____) ________________

Soc Sec#: ________-_____-________. Birth date: ___/ ___/ ___ Age: _____ Sex: _____

Marital Status: S M W D Sep Spouse's Name: ________________________

Emer. Contact: ______________________________ Phone: (_____) ____________ Cell: (____)______________

Your Employer: ______________________ Email: ____

How were you referred to us? ____

☐ By checking this box, I give permission for Myers Chiropractic Center to send occasional health newsletters with health and wellness tips.

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): ____

List any hospitalizations (include dates & reason): ____

List any auto accident injuries (include dates): ____

List any on the job injuries (include dates): ____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

____

List all current over-the-counter and prescription medications used (include reason used):

____

____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

____

Have you been under a physician's care in the past year? ☐ no ☐ yes (reason) ________________________

Have you ever been under chiropractic care? " ☐""pq ☐"{gu (describe) ________________________

If female, is there a possibility that you are pregnant? ☐ no ☐ yes

Do you smoke/use tobacco? ☐ no ☐ yes Exercise habits? ☐never ☐occasional ☐ frequent

Check any of the following symptoms you have noticed: (■ = Previously, ☐ = Now)

Headaches	Low back pain	Sensitive to light or sound
Dizziness or light-headed	Leg/foot numbness/tingling	Visual or hearing disturbance
Jaw pain, clicking, or locking	Leg/foot fatigue/weakness	Memory loss/problems
Pain or difficulty swallowing	Leg pain with walking	Irritability or depression
Neck pain or stiffness	Abdominal pain	Fatigue or loss of energy
Shoulder pain	Nausea or vomiting	Fainting or convulsions
Mid back pain	Diarrhea or constipation	Trouble with balance or coordination
Chest pain or cough	Blood in urine or stool	Sleep disturbances/problems
Pain/trouble breathing	Difficulty or pain w/ urination	Rashes (face, body, limbs)
Arm/hand numbness/tingling	Difficulty with sexual function	Joint pain or swelling
Arm/hand fatigue/weakness	Abnormal menstrual periods	Pain with exertion (activity, climbing stairs, etc.)

HAVE YOU HAD ANY OF THE FOLLOWING:

NOW:

- ☐ Pain worse at night
- ☐ Constant pain
- ☐ Unexplained weight loss
- ☐ Recent bacterial infection (30 days)
- ☐ Loss of bowel or bladder control
- ☐ Recent surgery (30 days)

EVER:

- ☐ History of cancer
- ☐ History of IV drug use
- ☐ History of blood transfustion

Patient Name: ___________________________

Claim # :______________________________

Information about your current condition/complaints

What is your primary complaint/problem? ___________________________

List other symptoms: ___________________________

When did your symptoms first begin (give date if possible)? ___________________________

Pain is: Constant ☐ Intermittent ☐ Is your condition getting worse? __________

What activities aggravate your condition? (list) ___________________________

What activities lessen your symptoms? (list) ___________________________

List all Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. ___________________________
2. ___________________________
3. ___________________________

Have you had: ☐ Xray ☐ MRI or CAT Scan ☐ EMG ☐ Bone Scan ☐ Blood Work

Who is your primary care physician? ___________________________

List all home remedies tried for this problem: ___________________________

Is your condition worse at certain times of the day or night? ___________________________

Does your condition interfere with: (yes/no) work ______ sleep ______ normal daily routine _______

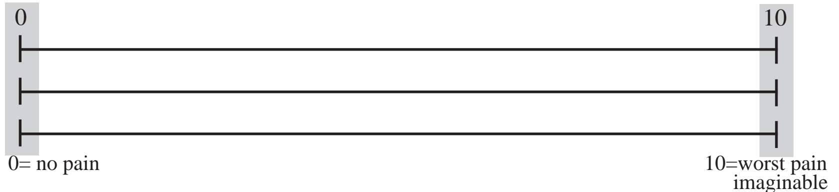
Have you had symptoms like this before? ☐ no ☐ yes (describe) ___________________________

Regarding your main complaint:

How bad is your pain?

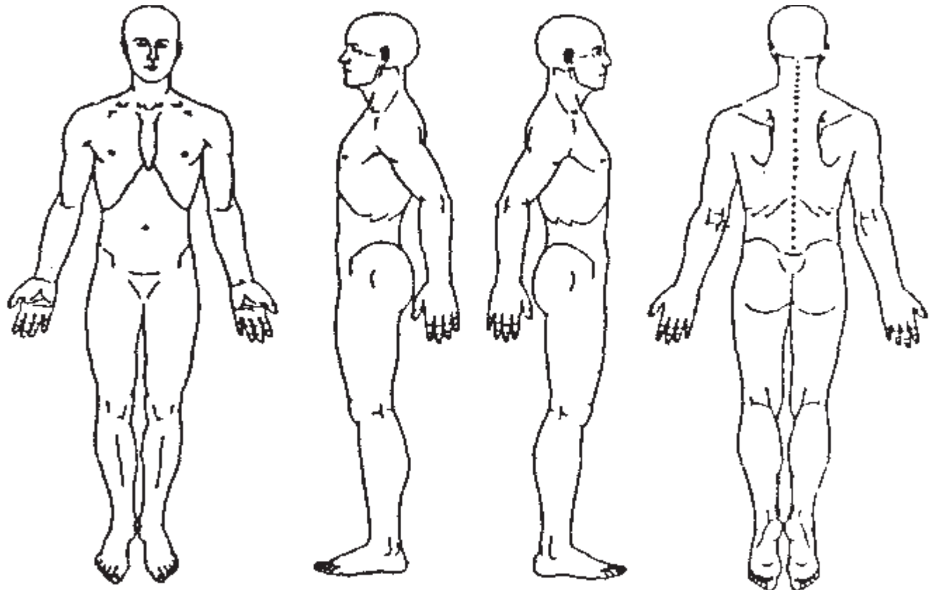
(make a o ctmon all 3 scales)

1. RIGHT NOW:
2. AVERAGE:
3. AT WORST:



Draw the area of your symptoms using these symbols: (mark on the figures)

XXX = ache
* = sharp/stab
ooo = numb/tingle
—> = shooting
/ / / / = stiff/tight



Pt. History 3.1
#1.04 SCSI©

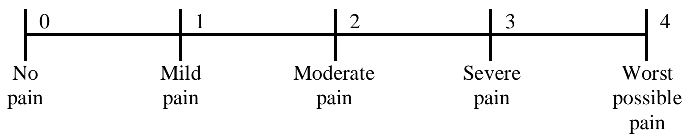
James Myers, DC Myers Chiropractic 15965 NE 85th St #101 Redmond, WA 98052 (425) 883-2245

Functional Rating Index

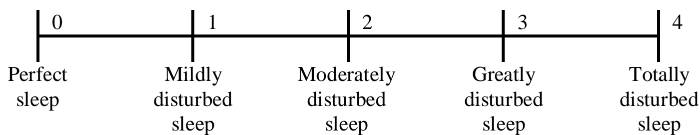
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

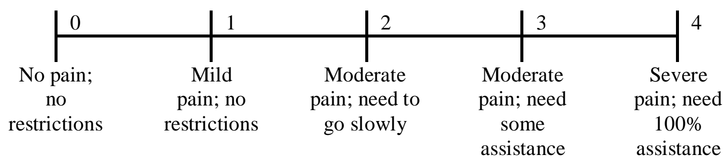
1. Pain Intensity



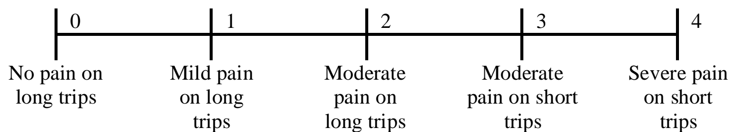
2. Sleeping



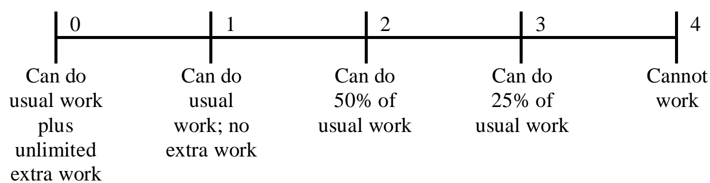
3. Personal Care (washing, dressing, etc.)



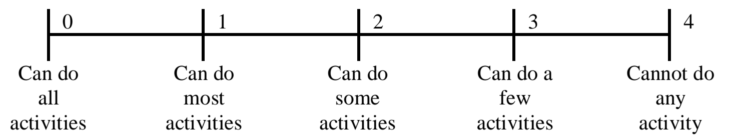
4. Travelling (driving, etc.)



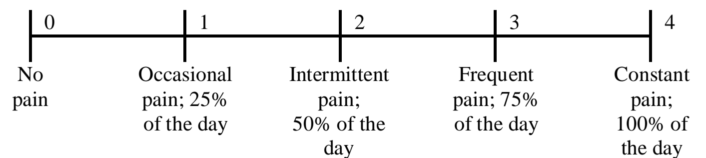
5. Work



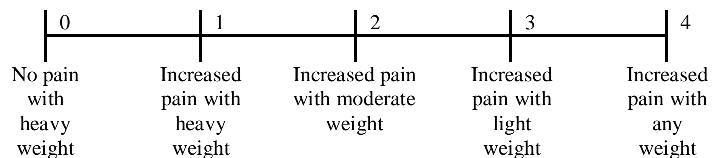
6. Recreation



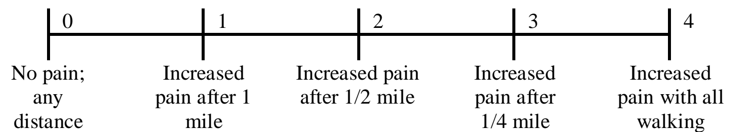
7. Frequency of Pain



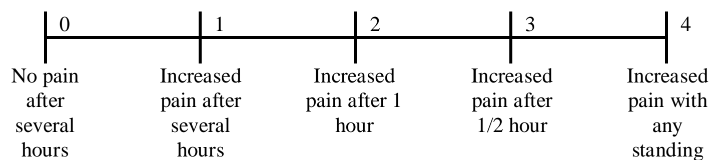
8. Lifting



9. Walking



10. Standing



____
Patient's Signature

____
Date

For Office Use Only:

Practitioner ID#: ______________________________

Total Score ____________ / 40

Clinical Diagnosis Codes:

Patient ID#: ______________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Myers Chiropractic Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

__________________________ __________________________________

Date Signature

____

Print Name

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