Chief Complaint – HPI (History of Present Illness)

Patient Name: ____________________________________ Case: _______________ Date: _______________ Dr: ____________

Chief Complaint: ___________________________________________

**Body Area(s) Involved:**
- Cervical
- Spine, Ribs, Pelvis
- Upper Extremity
- Lower Extremity

**Condition:**
- New → Acute or
- Chronic
- Recurrence (Acute)
- Exacerbation (Acute)
- Chronic

**Mechanism of Onset:**
- Auto: Driver/Passenger
- Pedestrian
- Work Related: Fall
- Falling Object
- Lifting
- Overexertion
- Repetitive Motion
- Other: ____________
- Other – Liability:
- Slip or Fall
- Other: ______________________________________________
- Other – No Liability:
- Etiology Unknown
- Overexertion
- Repetitive Use
- Slept Wrong
- Slip or Fall
- No Injury

**Description of Onset of Complaint:**

**Current Symptoms:**
- Pain
- Numbness
- Stiffness
- Weakness

**Location:** Left / Right / Bilateral

**Quality:**
- Burning
- Diffuse
- Dull/Aching
- Localized
- Radiating
- Sharp
- Shooting
- Stabbing
- Throbbing
- Tightness
- Tingling
- Other __________________

**Level of Impairment Due to Symptoms (Resting):**
0 1 2 3 4 5 6 7 8 9 10

**Level of Impairment Due to Symptoms (With Activity):**
0 1 2 3 4 5 6 7 8 9 10

**Duration:**
- Started: __________________
- Last Occurred: ______________ Last episode: __________________
- Worsened: ______________ Injury Occurred: __________________
- Resolved Previous Visit: ______________
- Accident Occurred: ______________

**Timing:**
- Worse: Morning
- Afternoon
- Night
- with Activity;
- Constant
- Intermittent

**Context:**
- Better with: Warm Temp
- Cold Temp
- Worse with: Warm Temp
- Cold Temp
- Damp

**Assoc Signs and Symptoms:**
- Blurred Vision
- Depression
- Dizziness
- Irritability/Mood Swing
- Localized Tingling
- Nausea
- Ringing in Ears
- Sleep Disturbance
- Stiffness

**Headaches:**
- Location:
- Occipital
- Frontal
- Left Temporal
- Right Temporal
- Parietal
- Sinus
- Quality:
- Dull
- Sharp
- Throbbing
- Stabbing
- Aura
- No Aura
- Types:
- Hat Band
- Cluster
- Migraine
- Tension
- Other: (frequency/duration/time of day)

**Radiation:**
- Left / Right / Bilateral

**Weakeness:**
- Left / Right / Bilateral

**Other Assoc Signs and Symptoms:**
- Aches
- Burning
- Cold limb(s)
- Difficulty walking
- Dizziness
- Ecchymosis
- Chronic fatigue
- Fever
- Heartburn
- Joint stiffness
- Muscle spasm
- Muscle weakness
- Nausea
- Numbness
- Pale bluish skin
- Panic
- Pins & needles
- Rhinorrhea (runny nose)
- Shortness of breath
- Sweating
- Swelling
- Tingling
- Vomiting
Symptoms Worse With: □ nothing helps □ activity □ bending □ applying cold □ applying heat □ massage □ movement □ OTC meds □ Rx meds □ rest □ stretching □ sitting □ standing □ twisting □ walking

Symptoms Better With: _____________________

Description of Work: __________________________________________
Occupation/Job Title: _______________________________________

Static Standing:
Sexual Activities:
Self Care:
Reading (Concentration):
Pet Care:
Lifting Frequency:
Work Activity Postures:
Extended Computer Use:
Feeding:
Household Chores:
Kneeling:
Lift Children:
Lifting:
Pet Care:
Reading (Concentration):
Self Care:
Self Care–Bathing:
Self Care–Dressing:
Self Care–Shaving:
Sexual Activities:
Sleep:
Static Sitting:
Static Standing:
Walking:
Yard Work:

No Effect → Unable to Perform

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Employment:

Occupation/Job Title: ____________________________ Work: _____ hrs / day or week
Description of Work: __________________________

Job Classification: □ Sedentary (<5lbs) □ Light (5-20lbs) □ Moderate (20-50lbs) □ Heavy (>50 lbs)
Lifting Frequency: □ Constant (67-100%/day) □ Frequent (33-66%/day) □ Occasional (0-32%/day)
Lifting Postures: □ with Arms □ High Near □ from Knee □ Off Posture □ from Torso

Work Activity Postures: (hrs/day)
□ bending: _____ h/d □ climbing: _____ h/d □ kneeling: _____ h/d □ pulling: _____ h/d □ pushing: _____ h/d
□ reaching: _____ h/d □ sitting: _____ h/d □ standing: _____ h/d □ twisting: _____ h/d □ walking: _____ h/d

Repetitive Activities: (hrs/day)
□ assembly/fine manipulation: _____ h/d □ computer use/typing: _____ h/d □ grasping: _____ h/d
□ hand tool use: _____ h/d □ operation of machinery controls: _____ h/d □ phone use: _____ h/d

Condition’s Effect on Job Performance:
□ Mild Painful (Can do) □ Mod Painful (limited ability) □ Mod/Sev Limited Duty □ Sev No Limited Duty □ Sev (can’t do limited duty)

Recreational Activity: Effects of Current Condition on Performance

No Effect □ Mild Painful (Can do) □ Mod Painful (Limited) □ Sev Unable to Perform

Mild – Moderate – Severe – Child’s Effect on Job

No Effect □ Mild Painful (Can do) □ Mod Painful (Limited) □ Sev Unable to Perform

Revision: rev 070113
Confidential Patient Health Record

How did you hear about us?  □ Family  □ Friend  □ Co-Worker  □ Close to home/work  □ Dr.  □ Yellow pages  □ Drove by  □ Hospital  □ Insurance Plan

Personal Information

Title:  □ Mr.  □ Ms.  □ Mrs.
Last: ___________________________  First: ___________________________  Middle: ___________________________
Suffix:  □ Jr  □ Sr  □ II  □ III
Birth Date: ___ / ___ / ______  Age: _____  Sex: Male / Female  SSN: ___________________________
Marital Status:  □ Single  □ Married  □ Widowed  □ Divorced  □ Separated
Address:  ___________________________________________  Apt # ______
City: ______________  State: ______  Zip: ______  Country: ______________  County: ___________
Home Phone: (______) _______ - _______ ext ______  Work Phone: (______) _______ - _______ ext ______
Cell Phone: (______) _______ - _______ ext ______  Fax #: (______) _______ - _______ ext ______
Email Address: ___________________________________________
Children (Names and Ages): ___________________________________________

Emergency Contact

Last: ___________________________  First: ___________________________  Middle: ___________________________
Relationship:  □ Spouse  □ Relative  □ Friend  □ Other ___________________________
Home Phone: (______) _______ - _______ ext ______  Cell Phone: (______) _______ - _______ ext ______
Work Phone: (______) _______ - _______ ext ______

Employment Information

Business Name: ___________________________________________
Phone: (______) _______ - _______  Fax #: (______) _______ - _______
Employer’s Email Address: __________________________________
Occupation/Job Title: ___________________________  Job Description ___________________________

Current Health Condition

Unwanted Condition (Why you are here today?): ___________________________

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.
Patient Name: ___________________________________ Date:________________

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

Key:  A=Ache   B=Burning   N = Numbness   P=Pins & Needles   S=Stabbing

When did this Condition BEGIN?   ____/______/_______
Has it ever occurred before?  ☐ Yes ☐ No. When? ____________
Is the Condition:  ☐ Auto Related  ☐ Job Related  ☐ Home Injury
☐ Slip or Fall  ☐ Lifting  ☐ Slept Wrong  ☐ Unknown Cause  ☐ Other
Explain: __________________________________________________________

Date of Accident: _______ Time of Accident: _______ am /pm
Condition/Pain STARTED on what Date: __________________________
Do you SUFFER with ANY OTHER Condition than which you are now consulting us?
________________________________________________________________
________________________________________________________________

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional:  ☐ I DENY having or have had any of the symptoms or problems listed below.
☐ chills  ☐ daytime drowsiness  ☐ night sweats  ☐ weight loss
☐ fatigue  ☐ fever  ☐ weight gain

Eyes/Vision:  ☐ I DENY having any of the symptoms or problems listed below.
☐ blindness  ☐ change in vision  ☐ field cuts  ☐ photophobia
☐ blurred vision  ☐ double vision  ☐ glaucoma  ☐ tearing
☐ cataracts  ☐ eye pain  ☐ itching  ☐ wear glasses/contacts

Ears, Nose and Throat:  ☐ I DENY having any of the symptoms or problems listed below.
☐ bleeding  ☐ ear drainage  ☐ hearing loss  ☐ nosebleeds  ☐ sore throat
☐ dentures  ☐ ear pain  ☐ history of head injury  ☐ postnasal drip  ☐ tinnitus
☐ swallowing difficulty  ☐ fainting  ☐ hoarseness  ☐ rhinorrhea
☐ discharge  ☐ frequent sore throats  ☐ loss of sense of smell  ☐ sinus infections
☐ dizziness  ☐ headaches  ☐ nasal congestion  ☐ snoring

Respiration:  ☐ I DENY having any of the symptoms or problems listed below.
☐ asthma  ☐ coughing up blood  ☐ sputum production
☐ cough  ☐ shortness of breath  ☐ wheezing
Patient Name: ____________________________ Date:________________

**Cardiovascular:**  □ I DENY having any of the symptoms or problems listed below.
- angina (chest pain or discomfort)  □ high blood pressure  □ shortness of breath with exertion or exercise
- chest pain  □ low blood pressure  □ swelling of legs
- claudication (leg pain/ache)  □ orthopnea (difficulty breathing lying down)  □ ulcers
- heart murmur  □ palpitations  □ varicose veins
- heart problems  □ paroxysmal nocturnal dyspnea
  (waking at night w/ shortness of breath)

**Gastrointestinal:**  □ I DENY having any of the symptoms or problems listed below.
- abdominal pain  □ diarrhea  □ indigestion  □ abnormal stool  □ vomiting blood caliper
- belching  □ difficulty swallowing  □ jaundice  □ abnormal stool color
- black - tarry stools  □ heartburn  □ nausea  □ abnormal stool consistency
- constipation  □ hemorrhoids  □ rectal bleeding  □ vomiting

**Female:**  □ I DENY having any of the symptoms/problems and/or using any of the items listed below.
- birth control  □ cramps  □ irregular menstruation  □ vaginal bleeding
- breast lumps/pain  □ frequent urination  □ pregnancy  □ vaginal discharge
- burning urination  □ hormone therapy  □ urine retention

**Male:**  □ I DENY having any of the symptoms or problems listed below.
- burning urination  □ frequent urination  □ prostate problems
- erectile dysfunction  □ hesitancy/ dribbling  □ urine retention

**Endocrine:**  □ I DENY having any of the symptoms or problems listed below.
- cold intolerance  □ excessive hunger  □ goiter  □ unusual hair growth
- diabetes  □ excessive thirst  □ hair loss  □ voice changes
- excessive appetite  □ abnormal frequency of urination  □ heat intolerance

**Skin:**  □ I DENY having any of the symptoms or problems listed below.
- changes in nail texture  □ hair loss  □ itching  □ skin lesions / ulcers
- changes in skin color  □ hives  □ paresthesias  □ varicosities
- hair growth  □ history of skin disorders  □ rash

**Nervous System:**  □ I DENY having any of the symptoms or problems listed below.
- dizziness  □ limb weakness  □ numbness  □ slurred speech  □ tremor
- facial weakness  □ loss of consciousness  □ seizures  □ stress  □ unsteadiness of gait/loss of balance
- headache  □ loss of memory  □ sleep disturbance  □ strokes

**Psychologic:**  □ I DENY having any of the symptoms or problems listed below.
- anhedonia  □ behavioral change  □ convulsions  □ memory loss
- anxiety  □ bi-polar disorder  □ depression  □ mood change
- loss or change in appetite  □ confusion  □ insomnia

**Allergy:**  □ I DENY having any of the symptoms or problems listed below.
- anaphalaxis  □ itching  □ chronic nasal congestion  □ sneezing
- food intolerance  □ acute nasal congestion  □ rash

**Hematologic:**  □ I DENY having any of the symptoms or problems listed below.
- anemia  □ blood clotting  □ bruising easily  □ lymph node swelling
- bleeding  □ blood transfusion  □ fatigue
PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for Same Condition: □ I have not seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) ____________________________

Type of Treatment: ____________________ Was the treatment beneficial in resolving condition? □ Yes □ No

Explain: _______________________________________________________________________________________

Previous Chiropractic Care: □ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor’s Name: ________________________ Location: ______________________ Date of Last Visit: ___________

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

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<th>Medication</th>
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Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

☐ ADD □ chicken pox □ headaches □ scoliosis
☐ atopic dermatitis (eczema) □ crohn’s/colitis □ hepatitis □ seizure disorder
☐ allergies/hayfever □ depression □ HIV □ sickle cell anemia
☐ anemia □ diabetes □ measles □ spina bifida
☐ asthma □ ear infections □ mumps □ other:
☐ bedwetting □ fetal drug exposure □ psoriasis
☐ cerebral palsy □ food allergies (list below) □ rash

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

☐ ADD □ cystic kidney disease □ hypertension □ psychiatric problems
☐ alzheimers □ depression □ influenza pneumonia □ scoliosis
☐ anemia □ diabetes (insulin dep) □ liver disease □ seizures
☐ arthritis □ diabetes (non insulin) □ lung disease □ shingles
☐ asthma □ eczema □ lupus erythema (discoid) □ past history of similar symptoms
☐ cancer □ emphysema □ lupus erythema (systemic) □ STD’s (unspecified)
☐ cerebral palsy □ eye problems □ multiple sclerosis □ suicide attempt(s)
☐ chicken pox □ fibromyalgia □ parkinson’s disease □ thyroid problems
☐ crohn’s/colitis □ heart disease □ unspecified pleural effusion □ vertigo
☐ CRPS (RSD) □ hepatitis □ pneumonia □ other:
☐ CVA (stroke) □ HIV □ psoriasis

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? □ yes or □ no.

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

☐ angioplasty □ cosmetic □ hysterectomy □ pacemaker insertion
☐ appendectomy □ D & C □ joint reconstruction □ rotator cuff
☐ caesarian section □ dental surgery □ joint replacement □ spinal fusion
☐ cardiac catheterization □ gall bladder □ knee repair □ tonsillectomy
☐ carpal tunnel repair □ hemorrhoidectomy □ laminectomy □ other:
☐ coronary artery bypass □ hernia repair □ mastectomy

4
Policy Holder's Name: ______________________________

Claim #: ______________________________

Carriers Phone #: (_______) ___________-_______________

Adjuster: ______________________________

Carrier: _____________________________________________

Policy # _______________________________

Personal Health Insurance Carrier: ______________________________

Education (please mark the highest level completed):

In Graduate School
In College
Associate/Technical Degree
In High School
Did Not Finish High School
High School Diploma
Post High School Classes
Doctorate

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

general family
father
mother
paternal grandfather
paternal grandmother
maternal grandfather
maternal grandmother
son(s)
daughter(s)
brother(s)
sister(s)

Social History

Alcohol: □ Never □ Social Consumption only □ Beer □ Liquor □ Wine ; _______ oz ______ glasses; □ Day □ Week □ Month

Diet (please mark all that apply): □ Low Calorie □ Low Carb □ Low Fiber □ Low Salt □ High Fat □ High Fiber □ High Protein □ High Salt □ Normal

Education (please mark the highest level completed): □ Preschool □ Elementary □ Middle □ Junior High □ VocTech □ In High School □ Did Not Finish High School □ High School Diploma □ Post High School Classes □ Assoc/Technical Degree □ In College □ College Degree □ In Graduate School □ Graduate Degree □ Doctorate □ Other:

Drugs: □ Deny any illegal drug use □ Deny use of IV drugs □ Have not used drugs since _________ □ Have used drugs for _________

Tobacco: □ Deny Tobacco Use □ Do not smoke cigars, cigarettes or pipe □ Live with a smoker □ Quit smoking

Smoke; # ________ per _______ Day □ Week □ Month □ Chew; # ________cans per _______ Day □ Week □ Year

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) □ Myself ONLY

□ Spouse □ Worker’s Comp □ Auto Insurance □ Medicare □ Medicaid □ Other (be specific):______

Personal Health Insurance Carrier: _________________ Health ID Card #: __________________________

Policy Holder’s Name: ______________________________ Group #: __________________________

Policy Holder’s Date of Birth: _______-____-______ Primary Care Physician: __________________________

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □ No Date: ________/_____/______ Time: ________am/pm

Carrier: ______________________________ Policy #: __________________________

Carriers Phone #: (_______) ___________-_______________ Adjuster: __________________________

Claim #: ______________________________

I acknowledge that I have received the Clinic’s Notice of Privacy Practices for protected health information.

Patient Print Name: ______________________________ Date: ______________

Patient’s Signature: ______________________________ Date: ______________