FOWLER CHIROPRACTIC PATIENT CASE HISTORY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth:_____

Telephone: (H) _____ (Cell) _____ (W) _____

Email: _____ Occupation: _____

Gender: Male Female Circle if you are Married Single Widowed Divorced

Where are you Employed? _____ Referred By: _____

Person Responsible for this Account: _____ Health Plan: _____

Subscribers Name: _____ ID# _____ GRP# _____

Surgeries:

1._____ Date: _____

2._____ Date: _____

Circle Any **Allergies:**

Animals Bees Chocolate Dairy Dust Eggs Latex Molds Ragweed/Pollen Shellfish

Seasonal Allergies Soaps Wheat X-Ray Dye Other: _____

Circle Any **Allergies to Medicine:**

Advil Amoxycillin Codeine Demerol Erythromycin Hydrocodone Morphine Penicillin
Percocet Sulfa Tylenol Vicodin Other: _____

Current Medication:

Name	**Reason**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Patient Health Questionnaire

Patient Name: _____ Date: _____

Please check if you have ever had a symptom listed below.

Past	Present		Past	Present	
☐	☐	Neck Pain	☐	☐	Shoulder Pain L☐ R ☐
☐	☐	Upper Back	☐	☐	Lower Back L☐ R ☐
☐	☐	Jaw L☐ R☐	☐	☐	Hip/Leg L☐ R☐
☐	☐	Dizziness	☐	☐	Ringing in Ears
☐	☐	Sciatica L☐ R☐	☐	☐	Depression
☐	☐	Arm L☐ R☐	☐	☐	Elbow L☐ R☐
☐	☐	Hand L☐ R☐	☐	☐	Headaches
☐	☐	Arthritis	☐	☐	Asthma
☐	☐	Broken Bones	☐	☐	Chest Pain
☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Eye/Vision	☐	☐	Fainting
☐	☐	Fatigue	☐	☐	Joint Stiffness
☐	☐	High Blood Pressure	☐	☐	Knee L☐ R☐
☐	☐	Heart Problems	☐	☐	Multiple Sclerosis
☐	☐	RA	☐	☐	Neurological
☐	☐	Pacemaker	☐	☐	Parkinson's
☐	☐	Polio	☐	☐	Prostate Problems
☐	☐	Spinal Cord Injury	☐	☐	Sprain/Strain
☐	☐	Stroke/Heart Attack	☐	☐	Other_____

HISTORY OF PRESENT ILLNESS

Major Complaint _____
_____
Date Problem Began ____/____/_____
How? _____
_____

Secondary Complaint (if applicable)
_____
Date Problem Began ____/____/_____
How? _____
_____

How is your condition changing? Better Worse Same Past/Previous Condition? Y N

Main reason for consulting the office:
▢ Become pain free
▢ Explanation of my condition
▢ Learn how to care for my condition
▢ Reduce symptoms
▢ Resume normal activity level

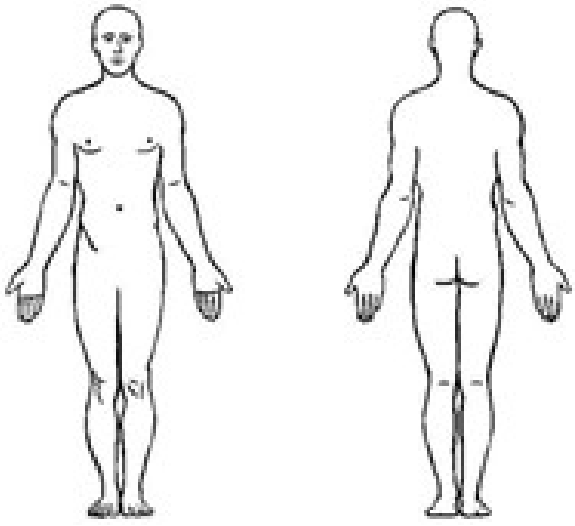
Describe nature of symptoms
▢ Sharp ▢ Dull ▢ Tight ▢ Numb
▢ Burning ▢ Shooting ▢ Tingling
▢ Stabbing ▢ Throbbing
▢ Radiating Pain
Other _____

Rate your pain on a scale of 1 to 10 (0= No pain and 10= Excruciating Pain).
■1 ▢2 ▢3 ▢4 ▢5 ▢6 ▢7 ▢8 ▢9 ▢10 Mild Moderate Severe

How often do you experience your symptoms? (Circle One)
Constantly (80-100%) Frequently (25-80%) Occasionally (0-25%)

What activities aggravate your condition? (working, exercise, etc.): _____

What makes your pain better? (ice, heat, massage, etc.): _____



_____ _____
Signature Date