Bosquez Chiropractic and Wellness Center

remove obstacles - restore function - improve performance - maximize potential

Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

center id	date

1 PATIENT INFORMATION

last name	first name	m.i.

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident?

What services interest you? (please mark all that apply)

- ☐ injury prevention
- ☐ balance and coordination training
- ☐ body composition
- ☐ other: _____
- ☐ treatment for pain
- ☐ nutritional/supplement counseling
- ☐ strengthening and stamina exercise
- ☐ spinal and body alignment
- ☐ patient education classes
- ☐ range of motion, mobility, or flexibility therapy

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ cold ☐ tingling ☐ burning

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

Using the scale below, rate how your **primary** compaint affects your life. (mark only one box below)

1	2	3	4	5	6	7	8	9	10
no pain or discomfort	no pain or discomfort	pain that does not affect my activiity	pain that affects my daily activity	pain that prevents performing my daily activities	pain that limits my work schedule	pain that prevents working at all	pain that prevents working and all personal activity	pain that keeps me bed ridden	pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

2 _____ 4 _____

3 _____ 5 _____

Do you have any other condition(s) other than what brings you here? ☐ yes ☐ no

If YES, list it here:

Please mark the areas of your complaints on the diagrams. Include any descriptors or comments, concerning your health complaints that were not mentioned above.

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3 LIFESTYLES & HABITS

How many hours of television do you watch a day? ☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

Do you usually snack while watching television? ☐ yes ☐ no

How many hours a day do you use a computer at work & home? ☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours a day do you ride in a car or other vehicle? ☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

How often do you exercise ☐ daily ☐ 3x's/week ☐ 2x's/week ☐ 1x/week ☐ I do not exercise

How long do your exercise work outs last? ☐ >1 hour ☐ 1 hour ☐ 30 minutes ☐ <30 minutes ☐ NA

What are your exercise activities? (mark all that apply) ☐ I don't exercise

- ☐ walking ☐ swimming ☐ group exercise classes
- ☐ stretching/flexibility ☐ yoga/Pilates ☐ running/treadmill/rowing/climbing
- ☐ weight lifting ☐ resistance bands ☐ other _____

Do you take a multivitamin? ☐ yes ☐ no If YES, what brand do you take? _____

List any nutritional supplements you are currently taking.

	supplement	reason		supplement	reason
1			3		
2			4		

How often do you use tobacco each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	_____ mother	_____ father	_____ brother	_____ sister
heart problems	_____ mother	_____ father	_____ brother	_____ sister
kidney problems	_____ mother	_____ father	_____ brother	_____ sister
cancer	_____ mother	_____ father	_____ brother	_____ sister
headaches	_____ mother	_____ father	_____ brother	_____ sister
back pain	_____ mother	_____ father	_____ brother	_____ sister
obesity	_____ mother	_____ father	_____ brother	_____ sister
poor conditioning	_____ mother	_____ father	_____ brother	_____ sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	☐ yes ☐ no	epilepsy	☐ yes ☐ no	low back pain	☐ yes ☐ no	polio	☐ yes ☐ no
anemia	☐ yes ☐ no	goiter	☐ yes ☐ no	measles	☐ yes ☐ no	rheumatic fever	☐ yes ☐ no
appendicitis	☐ yes ☐ no	heart disease	☐ yes ☐ no	mental disorder	☐ yes ☐ no	tuberculosis	☐ yes ☐ no
arthritis	☐ yes ☐ no	HIV positive	☐ yes ☐ no	mumps	☐ yes ☐ no	venereal infection	☐ yes ☐ no
cancer	☐ yes ☐ no	influenza	☐ yes ☐ no	pleurisy	☐ yes ☐ no	whiplash	☐ yes ☐ no
				pneumonia	☐ yes ☐ no	whooping cough	☐ yes ☐ no

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6 INJURIES

List any auto collisions that you were involved in, either as the driver or passenger, below. Begin with the most recent

	date of collision	type of collision	type of treatment received
1			
2			
3			

List any job injuries that you experienced below. Begin with the most recent.

	date of job injury	type of job injury	type of treatment received
1			
2			
3			

List any sports injuries that you experienced below. Begin with the most recent.

	date of sports injury	type of sports injury	type of treatment received
1			
2			
3			

List any other injuries caused by falls or impacts. Begin with the most recent.

	date of injury	type of injury	type of treatment received
1			
2			
3			

7 HOSPITAL / MEDICINE

Current family physician

Previous Chiropractor

Have you had breast implant surgery? □ yes □ no

Have you had knee or hip replacement? □ yes □ no

Do you have a pacemaker? □ yes □ no

Do you have any other implantable medical devices in your body? □ yes □ no

Mark all of the following procedures as they pertain to you.

vaccinations	□ yes □ no	tubes in ears	□ yes □ no	rectal surgery	□ yes □ no
tonsillectomy	□ yes □ no	appendectomy	□ yes □ no	sinus surgery	□ yes □ no
gall bladder removal	□ yes □ no	female/male surgery	□ yes □ no	hernia surgery	□ yes □ no
back surgery	□ yes □ no	stomach surgery	□ yes □ no	thyroid surgery	□ yes □ no
heart surgery	□ yes □ no				
upper extremities	□ yes □ no	please specify:			
lower extremities	□ yes □ no	please specify:			

List any prescription or over-the-counter medications you are currently taking.

	medication	reason		medication	reason
1			3		
2			4		

Have you ever had a lapse of memory? □ yes □ no Were you ever knocked unconscious? □ yes □ no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection?

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8 SYSTEM REVIEW

Mark the following conditions that are currently a cause of significant concern for you.(Check all that apply)

General

□ Consistent fainting	□ chills	□ convulsions	□ depression	□ dizziness
□ loss of weight	□ fatigue	□ fever	□ headache	□ loss of sleep
□ weight gain	□ neuralgia	□ night sweats	□ wheezing	□ nervousness

Gastro-Intestinal

□ constipation	□ diarrhea	□ gall bladder problems	□ hemorrhoids	□ jaundice
□ liver problems	□ nausea	□ stomach pain	□ poor appetite	
□ rectal bleeding	□ vomiting	□ vomiting blood	□ poor digestion	

Eye/Ear/Nose/Throat

□ asthma	□ crossed eyes	□ deafness	□ earache	□ hay fever
□ ear noises	□ enlarged thyroid	□ frequent colds	□ ear discharge	□ hoarseness
□ nasal obstruction	□ nose bleeds	□ pain in the eyes	□ poor vision	□ sinusitis
□ sore throat	□ tonsillitis			

Respiratory

□ chest pain	□ chronic cough	□ difficulty breathing	□ spitting phlegm	□ spitting blood

Muscle/Joints/Bones

□ backache	□ foot problems	□ pain between shoulders	□ painful tailbone	□ stiff neck
□ spinal curvature	□ swollen joints	□ tremors	□ twitching	□ weakness

Cardio-vascular

□ ankle swelling	□ high blood pressure	□ low blood pressure	□ heart trouble	□ pain over heart
□ poor circulation	□ rapid heart	□ slow heart	□ strokes	

Skin or allergies

□ bruise easily	□ dryness	□ eczema	□ hives	□ itching
□ sensitive skin				

Women

□ cramps	□ excessive flow	□ hot flashes	□ irregular cycle	□ painful periods

9 PREGNANCY *WOMEN ONLY*

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? □ yes □ no

On what date did your last period begin? _____

Mark the following situations as they pertain to you.

less than 10 days since the start of last period	□ yes □ no	complete or partial hysterectomy	□ yes □ no
tubal ligation	□ yes □ no	taking birth control pills	□ yes □ no

I understand and agree to the following:

A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services. Original x-rays are the clinics's property and copies or the original file(s) and report(s) will be released to me upon written request.

It is my responsibility to complete the clinic's forms accurately.

It is my responsibility to notify the doctor if any of my information has changed or requires updating.

_____
patient or guardian signature

_____
date