Foster Family & Sports Chiropractic, LLC New Patient Case History

Print Name:_____ DOB:_____

What is your major complaint that you are being seen for **TODAY**:

_____

What are any other complaints you have had in the **PAST**:

_____

How would you describe your pain?(circle) **Dull Ache Sharp Shooting Throbbing Numbness Burning**

Does your pain travel or shoot anywhere?(circle) **Yes No** If yes, where?_____

How long have you been feeling like this? _____

How did it start? _____

Have you had this before? (circle) **Yes No** Is this condition progressively getting worse? (circle) **Yes No**

Is this condition interfering with circle) **Work Sleep Daily Routine Other**:_____

What aggravates your condition?: _____

What helps you to feel better? (Ice, heat, stretching etc.):_____

Have you missed any time at work? **Yes No** Are you currently working? **Yes No**

Are you taking any medications? (Prescription) **Yes No**

If so, which kinds?_____

Are you taking any medications? (OTC) **Yes No**

If so, which kinds?_____

Have you seen any other doctor for this condition? **Yes No**

Any diagnostic test done? Specify (i.e. X-rays, MRI, CT, Ultra Sound) _____

Doctor's name:_____ MD DO DC DDS

What was prescribed/ what was the treatment:_____

Has it helped? **Yes No**

Auto Accident and Workman's Comp information:

Did your condition begin due to an: (circle one) **Auto Accident** or **Workman's Comp** Case?

What is the date of the accident? _____ What body part(s) were injured?_____

Has your case already been **REPORTED** to your employer/ insurance company? **Yes No**

By signing below I certify that the above information is true to the best of my knowledge. I clearly understand and agree that all services are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Finally, I authorize the release of my medical information relevant to my condition and treatment at this office to any insurance company or doctor as may be needed in the normal course of my care and treatment.

Signature:_____ Date:_____

Foster Family & Sports Chiropractic, LLC

New Patient Case History

Please Check/Circle All Present Symptoms

HEAD:
- ☐ Headache (circle all that apply)
  - ☐ Sinus (allergy)
  - ☐ Entire Head
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light Headedness
- ☐ Fainting
- ☐ Light sensitivity
- ☐ Blurred or Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing/buzzing in ears

NECK
- ☐ Neck pain
- ☐ Neck pain with movement (circle all that apply)
  - ☐ Forward
  - ☐ Backward
  - ☐ Turning to: **Left Right**
  - ☐ Bending to: **Left Right**
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Popping/grinding in neck
- ☐ Arthritis

SHOULDERS:
- ☐ Pain in shoulder joint: **Left Right**
- ☐ Pain across shoulders
- ☐ Bursitis: **Left Right**
- ☐ Arthritis: **Left Right**
- ☐ Cannot raise arm above: **Shoulder Head**
- ☐ Pinched nerve in shoulders: **Left Right**
- ☐ Muscle spasms in shoulders: **Left Right**

ARMS AND HANDS:
- ☐ Pain in upper arm: **Left Right**
- ☐ Pain in elbow: **Left Right**
- ☐ Movement aggravated
- ☐ Tennis elbow: **Left Right**
- ☐ Pain in fingers: **Left Right**
- ☐ Pain in hands: **Left Right**
- ☐ Pain in forearm : **Left Right**
- ☐ Pins and needles in arms: **Left Right**
- ☐ Pins/ needles in fingers: **Left Right**
- ☐ Numbness in arms: **Left Right**
- ☐ Fingers go to sleep: **Left Right**
- ☐ Swollen/sore joints in fingers
- ☐ Arthritis in fingers: **Left Right**
- ☐ Loss of grip strength: **Left Right**

MID BACK:
- ☐ Mid-Back pain
- ☐ Sharp stabbing pain
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Pain from back to front
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Irregular heart beat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Food

Allergies:_____

_____

LOW BACK:
- ☐ Low back pain
- ☐ Upper lumbar
- ☐ Lower lumbar
- ☐ Sacroiliac
- ☐ Slip disc
- ☐ Muscle spasms
- ☐ Arthritis
- ☐ Low back feels out of place

PAIN IS WORSE WHEN:
- ☐ Working
- ☐ Lifting
- ☐ Standing
- ☐ Sitting
- ☐ Bending
- ☐ Coughing
- ☐ Lying down
- ☐ Walking

HIPS, LEGS & FEET:
- ☐ Pain in buttocks: **Left Right**
- ☐ Pain in hip joint: **Left Right**
- ☐ Pain down legs: **Left Right**
- ☐ Knee Pain: **Left Right**
- ☐ Leg cramps: **Left Right**
- ☐ Cramps in feet: **Left Right**
- ☐ Pins and needles in legs: **Left Right**
- ☐ Numbness in legs: **Left Right**
- ☐ Numbness in feet: **Left Right**
- ☐ Numbness in toes: **Left Right**
- ☐ Swollen ankles/feet: **Left Right**

WOMEN ONLY:
- ☐ Menstrual pain
  Location:_____
- ☐ Irregularity
- ☐ Birth control, type: _____
- ☐ Hysterectomy
- ☐ Menopause
- ☐ Tumors
- ☐ Is there a chance you may be pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Surgeries: _____
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Loss of sleep_____ HRS/Night
- ☐ Abnormal weight gain/loss_____lbs
- ☐ Cups of coffee per day _____
- ☐ Cups of tea per day _____
- ☐ Cigarettes _____ packs a day
- ☐ Diabetes
- ☐ Hypo/hyperglycemia
- ☐ Other _____

Date of most recent -

XRAY & or MRI:_____

Date of most recent

Diagnostic Test:_____

Patients Remarks:

_____

_____

_____