

# Hillgartner Chiropractic

Ballwin Chiropractic Center, P.C.

## Patient Case History

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ M S W D  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Referred By:  Friend  Relative  Newspaper Ad  Yellow Pages  Other  
Which one of our patients should we thank for referring you? \_\_\_\_\_  
Date of most recent physical exam: \_\_\_\_\_

Are you here today because you were injured while working, in a motor vehicle collision or in another accident?  Yes  No When? \_\_\_\_\_

My current symptoms/complaints today:

(Headaches) (Neck Pain) (Neck Stiffness) (Shoulder/Arm Pain) (Upper-Back Pain) (Mid-Back Pain)  
(Low-Back Pain) (Hip Pain) (Pelvic Pain) (Leg Pain) (Asthma) (Stomach Pain) (Numbness)  
(Dizziness) (Bedwetting) (Stress) (Urinary/Bowel Dysfunction) (Menstrual Problems) (Other \_\_\_\_\_)

Other doctors seen for your complaint(s):

Chiropractic care (D.C) Were you satisfied? Yes  No  Name: \_\_\_\_\_  
 Medical care (M.D.) Were you satisfied? Yes  No  Name: \_\_\_\_\_  
 Other care Were you satisfied? Yes  No  Name: \_\_\_\_\_

Medications and drugs you are taking:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

\*\*Female Patients\*\* Are you pregnant at this time? (Yes) (No) Due date: \_\_\_\_\_

List major surgeries you have had: \_\_\_\_\_

Office Policies: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, that Hillgartner Chiropractic/Ballwin Chiropractic Center will prepare the necessary reports and claims to assist me in reimbursement from the insurance company and that any amount authorized to be paid directly to Hillgartner Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that no cures are promised and any risks regarding care will be explained to me. I now authorize Hillgartner Chiropractic to proceed with necessary care and treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

**My primary complaints/ symptoms:**(briefly describe) \_\_\_\_\_

✓ Check all that apply:

- \_\_\_\_\_ Is this your first attack?
- \_\_\_\_\_ Is your condition due to a recent injury?
- \_\_\_\_\_ Is your pain constant?
- \_\_\_\_\_ Is your pain intermittent?
- \_\_\_\_\_ Does your pain radiate?
- \_\_\_\_\_ Did your pain begin suddenly?
- \_\_\_\_\_ Did your pain begin slowly?
- \_\_\_\_\_ Does standing increase your pain?
- \_\_\_\_\_ Does sitting or driving increase your pain?
- \_\_\_\_\_ Does your pain awaken you from sound sleep?
- \_\_\_\_\_ Does walking up steps increase your pain?
- \_\_\_\_\_ Do you have weakness in your arms or legs?
- \_\_\_\_\_ Does coughing or sneezing increase your pain?
- \_\_\_\_\_ Does lifting cause increased back or neck pain?
- \_\_\_\_\_ Do you have back pain on forward bending?
- \_\_\_\_\_ Is your back/neck tender to pressures & twists?
- \_\_\_\_\_ Does turning your head cause neck or back pain?
- \_\_\_\_\_ Do you feel like fainting when turning your head?
- \_\_\_\_\_ Do you have numbness in any part of your body?
- \_\_\_\_\_ Do you feel like you are falling over when walking?
- \_\_\_\_\_ Do you get headaches frequently?
- \_\_\_\_\_ Do you often feel lightheaded?
- \_\_\_\_\_ Have you had whiplash injury?
- \_\_\_\_\_ Have you had back or neck surgery? When?
- \_\_\_\_\_ Have you been advised to have spinal surgery?
- \_\_\_\_\_ Have you been told you have a "spinal defect"?
- \_\_\_\_\_ Have you been diagnosed with spinal arthritis?
- \_\_\_\_\_ Are you having problems with bowel control?
- \_\_\_\_\_ Are you having problems with bladder control?
- \_\_\_\_\_ Do you have vertigo (dizziness)?
- \_\_\_\_\_ Do you have tinnitus (ringing in the ears)?
- \_\_\_\_\_ Have you had vomiting episodes recently?
- \_\_\_\_\_ Do you have visual problems?
- \_\_\_\_\_ Do you often feel nauseated?
- \_\_\_\_\_ Have you noticed speech changes?
- \_\_\_\_\_ Have you noticed hoarseness?
- \_\_\_\_\_ Do you have difficulty swallowing?

**Daily Activities:**

- Have you missed work due to your complaint? (Yes) (No)
- How many hours do you normally work per week? \_\_\_\_\_
- What makes your complaint better? (rest) (medication) (heat) (ice)
- What time of the day is your complaint worse? (morning) (afternoon) (night)
- What particular work or home activities have you eliminated? \_\_\_\_\_
- What particular sport or exercise routine do you participate in? \_\_\_\_\_
- Do you take regular nutritional supplements? \_\_\_\_\_
- How many hours per day do you sleep? \_\_\_\_\_
- How many hours per day do you use a computer? \_\_\_\_\_

**Health Risk Factors:**

- Tobacco use? (Yes) (No) How much? \_\_\_\_\_
- Alcohol use? (Min) (Mod) (Heavy) (None)
- High blood pressure? (Yes) (No)
- Emphysema? (Yes) (No)
- Diabetes? (Yes) (No)
- Cardiovascular Disease? (Yes) (No)
- Birth Control Pills? (Yes) (No)
- HIV positive? (Yes) (No)
- Cancer? (Yes) (No)
- Epilepsy/ Seizures? (Yes) (No)
- Mental Disorder? (Yes) (No)
- Venereal Disease? (Yes) (No)
- Do you take anticoagulation medication? (Yes) (No)
- Do you take anti-inflammatory medication? (Yes) (No)
- Do you take hormone therapy medication? (Yes) (No)

List any other conditions the doctor should be aware of:

Patient Name: \_\_\_\_\_

### INJURIES

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

<u>type of collision</u>	<u>type of treatment received</u>	<u>date of collision</u>
1.		
2.		
3.		

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

<u>type of job injury</u>	<u>type of treatment received</u>	<u>date of job injury</u>
1.		
2.		
3.		

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

<u>type of sports injury</u>	<u>type of treatment received</u>	<u>date of sports injury</u>
1.		
2.		
3.		

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

<u>type of injury</u>	<u>type of treatment received</u>	<u>date of injury</u>
1.		
2.		
3.		

## Functional Rating Index Activities of Daily Living

Answer the following only if you have neck or back pain. To properly assess your condition, we must understand how much your neck and/or back problems have 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

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

### 2. Sleeping

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

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

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

### 4. Travel (driving, etc.)

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

### 5. Work

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

### 6. Recreation

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

### 7. Sitting

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

### 8. Lifting

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

### 9. Walking

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain

### 10. Standing

0-----1-----2-----3-----4  
No Mild Moderate Severe Worst  
Pain Pain Pain Pain Possible  
Pain



Patient Name: \_\_\_\_\_

**FAMILY HISTORY**

(✓) Mark the following conditions as they pertain to your immediate family.

	mother	father	brother	sister	children
diabetes					
hypertension					
heart problems					
kidney problems					
cancer					
obesity					
scoliosis					
back problems					
osteoporosis					
headaches					
birth defects					

**SYSTEM REVIEW**

Mark the following conditions you are **currently** experiencing (past 30 days).

**General**

- allergies
- loss of weight
- weight gain
- chills
- fatigue
- itching
- convulsions
- fever
- night sweats
- depression
- hives
- wheezing
- bruise easily
- loss of sleep
- nervousness

**Gastrointestinal**

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

**Eye/ Ear/ Nose/ Throat**

- asthma
- ear noises
- nasal obstruction
- tonsillitis
- double vision
- enlarged thyroid
- nose bleeds
- difficulty swallowing
- deafness
- frequent colds
- pain in eyes
- earache
- hay fever
- poor vision
- ear discharge
- loss of smell
- sinusitis

**Respiratory**

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

**Muscles/ Joints/ Bones**

- backache
- deformity
- foot problems
- swollen joints
- shoulder pain
- knee pain
- hip pain
- limping
- painful tailbone
- weakness

**Cardiovascular**

- ankle swelling
- poor circulation
- low blood pressure
- chest pain
- rapid heart
- coughing blood
- slow heart
- weakness
- shortness of breath
- high blood pressure

**Genitourinary**

- burning on urination
- inc. urination/ night
- inc. urination/ day
- painful urination
- blood in urine
- kidney stones
- recurrent bladder infection
- difficulty starting