DrOhmyback.com

Patient Case History

PEACE OF MIND, BALANCED BODY ™

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

1 PATIENT INFORMATION

Clinic id	Date

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? ☐ yes ☐ no

What services interest you? (mark all that apply)

- ☐ Injury prevention
- ☐ Balance and coordination training
- ☐ range of motion, mobility, or flexibility therapy
- ☐ Treatment for pain
- ☐ Spinal and body alignment
- ☐ Strengthening and stamina exercise
- ☐ Patient education classes
- ☐ Body composition counseling
- ☐ nutritional and supplement counseling
- ☐ Other:

What is your **primary** complaint?

How does the **primary** complaint feel? ☐ Dull/achy ☐ Sharp ☐ Numb ☐ Tingling ☐ Burning ☐ Cold

How often do you experience the **primary** complaint? ☐ Constantly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

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

☐ no pain or discomfort	☐ slight discomfort	☐ pain that does not affect my activity	☐ pain that affects my daily activities	☐ 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.

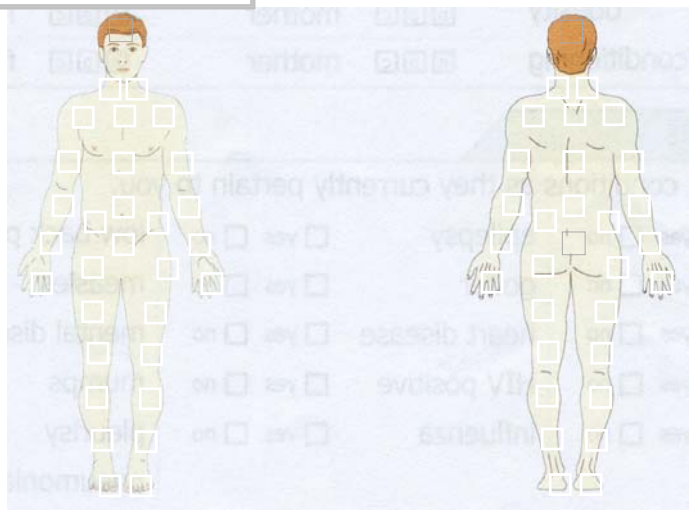
2) 4)

3) 5)

Do you have any other condition other than what bring you here ☐ yes ☐ no

If YES, list it here:

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



3 LIFESTYLES & HABITS

Patients name:

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

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

How may hour per day do you use a computer at work or home? ☐ < 1 ☐ 1 -3 ☐ 3 - 5 ☐ >5

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

How log do you exercise? ☐ daily ☐ 3x'/week ☐ 2x's/week ☐ 1x/week ☐ I don't exercise

How long do your exercise work outs last? ☐ >1 hr ☐ 1 hr ☐ ½ hrs ☐ < ½ hrs ☐ NA

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

☐ Walking
☐ Stretching/flexibility
☐ Running/treadmill/rowing/climbing
☐ Swimming
☐ Yoga/Pilates
☐ Group exercise classes
☐ Weight lifting
☐ Resistance Bands
☐ other

Do you take a multi-vitamin? ☐ Yes ☐ No If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

Supplement	Reason	Supplement	Reason
1.		3.	
2.		4.	

How often do you use tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly ☐ yearly

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 pertain to you

	yes	no		yes	no		yes	no		yes	no
Alcoholism	☐	☐	Epilepsy	☐	☐	low back pain	☐	☐	Polio	☐	☐
Anemia	☐	☐	Goiter	☐	☐	Measles	☐	☐	Rheumatic fever	☐	☐
Appendicitis	☐	☐	Heart disease	☐	☐	Mental disorder	☐	☐	Tuberculosis	☐	☐
Arthritis	☐	☐	HIV positive	☐	☐	Mumps	☐	☐	Venereal infection	☐	☐
Cancer	☐	☐	Influenza	☐	☐	Pleurisy	☐	☐	whiplash	☐	☐
						Pneumonia	☐	☐	Whooping cough	☐	☐

6 INJURIES

Patients name:

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

	Type of collision	Type of treatment received	Date of Collision
1.			
2.			
3.			

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

	Type of job injury	Type of treatment received	Date of job injury
1.			
2.			
3.			

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

	Type of sports injury	Type of treatment received	Date of sports injury
1.			
2.			
3.			

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

	Type of injury	Type of treatment received	Date of injury
1.			
2.			
3.			

7 HOSPITAL / MEDICINE

Have you had breast implant surgery?	☐ yes	☐ no
Have you had knee or hip replacement surgery?	☐ 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.

	yes	no		yes	no		yes	no
Vaccinations	☐	☐	Tubes in ears	☐	☐	Sinus surgery	☐	☐
Tonsillectomy	☐	☐	Appendectomy	☐	☐	Hernia surgery	☐	☐
Gall bladder removal	☐	☐	Female/male surgery	☐	☐	Thyroid surgery	☐	☐
Back surgery	☐	☐	Rectal surgery	☐	☐	Stomach surgery	☐	☐

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

	Medication	Reason		Medication	Reason
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you ever had a lapse of memory?	☐ yes	☐ no
Were you ever knocked unconscious?	☐ yes	☐ no
Have you ever had a spinal tap or spinal injection?	☐ yes	☐ no

List any broken bones or dislocations that you had.

8 SYSTEM REVIEW

Patients name:

Mark the following conditions that are **currently** a cause of significant concern for you.

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	☐ hemorrhoids	☐ Jaundice
☐ Liver problems	☐ Nausea	☐ Stomach pain	☐ Poor appetite	☐ Poor digestion
☐ Rectal bleeding	☐ Vomiting	☐ Vomiting blood		

Eye/Ear/Nose/Throat

☐ Asthma	☐ Crossed eyes	☐ Deafness	☐ earache	☐ Ear discharge
☐ Ear noises	☐ Enlarged thyroid	☐ Frequent colds	☐ Hay fever	☐ Hoarseness
☐ Nasal obstruction	☐ Nose bleeds	☐ Pain in eyes	☐ Poor vision	☐ Sinusitis
☐ Sore throat	☐ Tonsillitis			

Respiratory

☐ Chest pain	☐ Chronic cough	☐ Difficulty breathing	☐ Spitting blood	☐ Spitting phlegm

Muscles/Joints/Bones

☐ Backache	☐ Foot problems	☐ Pain bet. 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? _____

Do you want to take a pregnancy test now? ☐ yes ☐ no

Which one of our patients referred you to our clinic? _____

OFFICE USE ONLY

Result of clinic pregnancy test + -

By my eSignature below, I certify that I have read, fully understand and accept all terms of the foregoing statement. Please signify your acceptance by entering the information requested in the fields below.

I understand agree to the following:

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

By my eSignature below, I certify that I have read, fully understand and accept all terms of the foregoing statement. Please signify your acceptance by entering the information requested in the fields below.

Full Name: _____ Date: _____

Print Send