TOTAL HEALTH CHIROPRACTIC, LLC

(DBA: Total Health Wellness Center)

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PATIENT INTAKE & CASE HISTORY

Please complete this form as accurately as possible. Your answers help the doctor understand your current concerns, relevant health history, and how your condition affects your daily life.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/ZIP: _____

Cell/Home Phone: _____ Email: _____

Occupation/Employer: _____ Referred By: _____

CURRENT HEALTH COMPLAINT

Primary complaint / reason for today's visit: _____

When did this begin? _____ Onset: ☐ Sudden ☐ Gradual Cause (if known): _____

How does it feel? ☐ Dull/Achy ☐ Sharp ☐ Numb ☐ Tingling ☐ Burning ☐ Stiff/Tight ☐ Other: _____

How often? ☐ Constant ☐ Daily ☐ Intermittent/Occasional Is it: ☐ Improving ☐ Worsening ☐ About the same

Pain/symptom level NOW: ____/10 BEST: ____/10 WORST: ____/10

What makes it worse? _____ What makes it better? _____

Does this interfere with: ☐ Work ☐ Sleep ☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Exercise ☐ Household/ADLs

Describe your most significant limitation: _____

Have you missed work because of this condition? ☐ No ☐ Yes If yes, dates/last day worked: _____

What do you believe caused or contributed to this problem? _____

OTHER CURRENT COMPLAINTS

2. _____ 3. _____ 4. _____

Other condition(s) or concern(s) you want the doctor to know about: _____

_____

SYMPTOM / BODY LOCATION

Mark or check all areas involved. Use R/L where appropriate; note numbness, tingling, burning, or radiation in the space below.

☐ Head/Jaw	☐ Neck	☐ Upper Back	☐ Mid Back
☐ Low Back	☐ Shoulder R/L	☐ Arm/Elbow R/L	☐ Hand/Wrist R/L
☐ Hip/Buttock R/L	☐ Leg R/L	☐ Knee R/L	☐ Ankle/Foot R/L
☐ Chest/Ribs	☐ Abdomen	☐ Other: _____	

Describe exact location/radiation or other symptoms: _____

CARE FOR THIS CURRENT CONDITION

Have you previously been evaluated or treated for this problem? ☐ No ☐ Yes Provider/Facility: _____

Treatment received: _____ Did it help? ☐ Yes ☐ No ☐ Temporarily

Testing/imaging for this condition: ☐ None ☐ X-ray ☐ MRI ☐ CT ☐ Other: _____ Date/Facility: _____

BRIEF LIFESTYLE / HABITS

Exercise: ☐ Regularly ☐ Occasionally ☐ Rarely/Never Tobacco/Nicotine: ☐ Never ☐ Current ☐ Former

Alcohol: ☐ None ☐ Occasional ☐ Regular Typical work demands (lifting, sitting, computer work, repetitive activity, etc.):

_____

_____

MEDICAL & HEALTH HISTORY

SIGNIFICANT MEDICAL CONDITIONS - CHECK CURRENT OR RELEVANT HISTORY

☐ High blood pressure	☐ Heart disease/problem	☐ Diabetes	☐ Cancer
☐ Arthritis	☐ Osteoporosis	☐ Seizure/epilepsy	☐ Stroke/TIA
☐ Asthma/lung disease	☐ Kidney disease	☐ Thyroid disorder	☐ Bleeding/clotting disorder
☐ Neurologic disorder	☐ Autoimmune disorder	☐ Mental health condition	☐ Other: _____
☐ None known			

Please explain any checked condition that may affect your care: _____

SURGERIES / HOSPITALIZATIONS / IMPLANTED DEVICES

Major surgeries or hospitalizations: ☐ None If yes, type/date: _____

Spinal surgery: ☐ No ☐ Yes Joint replacement: ☐ No ☐ Yes Pacemaker/defibrillator: ☐ No ☐ Yes

Other implanted device/metal: ☐ No ☐ Yes If yes, describe: _____

Prior spinal injection(s): ☐ No ☐ Yes Approx. date/type: _____

MEDICATIONS & ALLERGIES

Current prescription and over-the-counter medications (or attach list): _____

_____

Medication allergies/adverse reactions: ☐ None known If yes: _____

SIGNIFICANT PAST INJURIES / ACCIDENTS

List significant motor vehicle, work, sports, fall, fracture/dislocation, or other injuries that may be relevant to your current care.

Injury / Accident	Approx. Date	Treatment / Outcome

REVIEW OF SYSTEMS - CHECK CURRENT SIGNIFICANT CONCERNS

GENERAL / NEUROLOGICAL	CARDIO / RESPIRATORY	GI / MUSCULOSKELETAL / OTHER
☐ Fever/chills/night sweats	☐ Chest pain	☐ Abdominal pain
☐ Unexplained weight loss/gain	☐ Shortness of breath	☐ Nausea/vomiting
☐ Dizziness/fainting	☐ Heart rhythm/palpitations	☐ Bowel changes
☐ Headaches	☐ High/low blood pressure	☐ Joint swelling
☐ Numbness/tingling	☐ Persistent cough	☐ Muscle weakness
☐ Weakness/paralysis	☐ Other: _____	☐ Skin rash/allergy
☐ Seizures/convulsions		☐ Other: _____

Explain any significant checked symptoms: _____

PREGNANCY / IMAGING SAFETY - WHEN APPLICABLE

Could you currently be pregnant? ☐ No ☐ Yes ☐ Unsure ☐ Not applicable Date last menstrual period (if applicable): _____

Please inform the doctor or staff if pregnancy is possible before any imaging is performed.

PATIENT CERTIFICATION

I certify that the information provided on this form is true and complete to the best of my knowledge. I understand that this information will become part of my health record. I agree to inform the Practice of significant changes in my health, medications, or other information that may affect my care.

Patient/Guardian Name (Print): _____

Patient/Guardian Signature: _____ Date: _____

If signed by guardian/representative, relationship to patient: _____