Cavanaugh Chiropractic

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Name: _____ File Number: _____

Date: _____

Patient information:

Name_____ Date _____ Patient Number_____

Address _____ City _____

State _____ Zip _____ SEX ☐ F ☐ M

Birthdate _____ Email _____

Phone _____ Cell _____ Work_____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____

State _____ Zip _____

Who may we thank for referring you? _____

Spouse/Parent:

Spouse/Parent Name _____ Spouse/Parent Employer _____

Emergency Contact _____ Phone _____

Age _____

Pregnant _____ Weeks_____

Pacemaker_____

Habits

☐ current every day smoker ☐current someday smoker ☐former smoker

☐never smoker ☐drinking

☐coffee ☐soft drinks

Exercise

☐None

☐Moderate

☐Daily

Family History

	diabetes	cancer	back pain	other
mother	☐	☐	☐	☐
father	☐	☐	☐	☐
Siblings	☐	☐	☐	☐

Are you currently taking any vitamins or medications? ☐ Yes ☐No

Please list your vitamins and medications:

_____

_____

Do you have any allergies? ☐ Yes ☐ No

Please list your allergies:

_____

_____

Have you ever had any surgeries? ☐ Yes ☐ No

Please list your surgeries:

_____

_____

Have you had x-rays for your what you are being seen for today? ☐ Yes ☐ No

When were these x-rays taken? _____

Where were they taken? _____

Have you received previous treatment for your current condition?

_____

_____

Do you have any past medical conditions you would like us to know about?

_____

_____

Patient Name: _____ Chart Number: _____

Symptom: _____

1.) When, or approximately when, did the complaint begin? _____
2.) Did it begin **gradually** or **suddenly**? (circle one)
3.) Describe the exact location of your pain/problems? (Please be as specific as possible)

_____

4.) How did your symptoms begin?

_____

5.) Describe the quality of the symptom you feel? (Circle all that apply)
   - dull, sharp, burning, aching, gnawing, throbbing, shooting, piercing, stabbing, deep, nagging, stiff, other (please describe): _____

6.) Does your pain radiate to other parts of your body (circle one)? Yes No
   - If yes, where does the symptom radiate: _____

7.) On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
8.) what percentage of the time do you experience the symptom at the above intensity:
   - 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

9.) Have you ever experienced symptoms like this before? Please explain what was hurt and how it got injured? _____

_____

10.) Has your condition been getting **worse**, **better**, or **no change** since this episode began? (circle one)
11.) What have you tried that makes your condition better? (circle all that apply)
   - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

12.) what are activities that make your condition worse? (circle all that apply)
   - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):_____

13.) Is the symptom worse at certain times of the day or night? (please circle)
   - no difference morning afternoon evening night other: _____

14.) Has there been any change in bodily functions due to your condition? (circle all that apply)
   - no urination defecation respiration digestion vision smell taste other: _____

15.) How has your condition affected your daily activities?

_____

_____

16.) Have you received treatment for this condition or episode prior to today's visit: (circle all that apply)
   - No
   - Anti-inflammatory
   - Pain medication
   - Muscle relaxers
   - Trigger point injections
   - Cortisone injection
   - Surgery
   - Massage
   - Physical therapy
   - Chiropractic
   - Other _____

Cavanaugh Chiropractic
Review of Systems

Patient Name:_____ Today's Date:_____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

Signature:_____ Date:_____