MEYER CHIROPRACTIC CENTER

# CONFIDENTIAL PATIENT CASE HISTORY (HPI)

Describe your major Symptoms /Complaint: _____

_____

When did this condition begin? (Enter a specific date) _____/_____/_____

How did your symptoms start? (fall,lifting,etc) _____

How long have you had this condition? _____

How often do you experience your symptoms? (1) Constantly (76-100 % of the time) (2) Frequently (51-75% of the time) (3) Occasionally (26-50% of the time) (4) Intermittently (0-25% of the time)

Have you had this or similar conditions in the past? _____

Average Pain Intensity: Last 24 Hours no pain 1 2 3 4 5 6 7 8 9 10 worst pain
Past Week no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating ☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other _____

Do any positions make it feel worse?_____

Do any positions make it feel better?_____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

How much have your symptoms interfered with the usual daily activities? (Including work, home and housework)

(1) Not at all (2) a little bit (3) Moderately (4) Quite a bit (5) Extremely

In general, how would you say your overall health is right now?

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Other doctors or therapists who have treated THIS condition _____

List surgical operations and years: _____

Do you have a family physician? Name _____

Medications, dosage and frequency: _____

_____

Have you been in an auto accident or had any other personal injury? ☐ Yes ☐ No

Describe: _____

Patient Signature _____ Date _____

Patient Name _____

Parent/Guardian Signature _____ Date _____