Full Motion LIFE & SPORT

6013-B Wilson Blvd
Arlington, VA 22205
Phone: 703-536-5900

PATIENT CASE HISTORY

Name:______________________________ Home #:______________

Address:______________________________ Work #:______________

City-State:____________________ Zip:__________ SS#:______________

Name you prefer to be addressed as:______________ Date of Birth:______________ Age:________

Primary Care Physician:______________ Referred to our clinic by:______________

Optional – Email address (To receive our monthly E-newsletter examining noteworthy health studies):______________

What is your primary complaint? (i.e. Headaches, neck pain, lower back, foot, etc.)______________

____

When was the first time you suffered from this complaint?______________

Is this pain recurrent? ☐ Yes ☐ No If yes, how often does it recur?______________

What do you think caused your pain? (i.e. Car accident, occupation, etc.)______________

What decreases your pain? (i.e. Pain medication, ice, heat, laying down, stretching, etc.)______________

____

What increases your pain? (i.e. Sitting too long, reading, walking, bending, etc.)______________

____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse Is it interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine

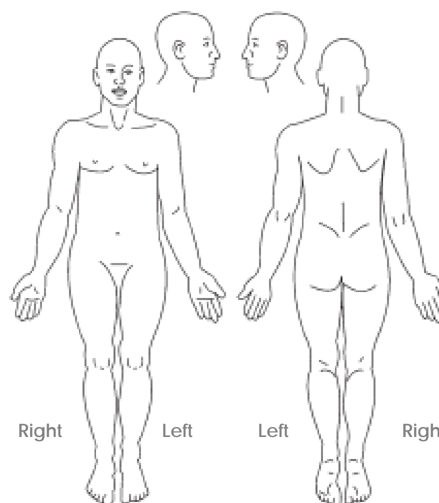
Have you experienced any numbness, pain, weakness or tingling in your arms, hands, legs, or feet? ☐ Yes ☐ No

If yes, where?______________________________

Use the letters listed below to indicate the *type* and *location* of your pain and/or sensations on the figure to the right: (i.e. If you have a stabbing pain in your neck, mark an "S" on the neck where the pain is.)

KEY

A	=	Ache
B	=	Burning
S	=	Stabbing
N	=	Numbness
P	=	Pins & Needles
O	=	Other



Please make a vertical mark (|) along each line to the right to indicate the severity of your pain at its worst, best, and average:

0 = No pain……**10** = Most severe pain imaginable

0______________________________**10** ◀ At its Worst

0______________________________**10** ◀ At its Best

0______________________________**10** ◀ On Average

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Please list any other treatments that you have ever received for your primary complaint:

Doctor's Name:______________________________Phone #:______________

MRI / X-ray results:______________________________

Type of treatment given & the success of that treatment:______________________________

Doctor's Name:______________________________Phone #:______________

MRI / X-ray results:______________________________

Type of treatment given & the success of that treatment:______________________________

Have you ever received treatment from a chiropractor? ❑ Yes ❑ No

Have you been involved in any recent trauma? (i.e. Fall, accident, etc.)______________________________

If yes, please describe:______________________________

Family History

Please list any of diseases that run in your family:

Relative	Age (If living)	Age (At death)	Cause of death	State of health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

Social History

Check the boxes and fill in the blanks where needed:

Current weight: Have you recently lose or gained weight?

Mental work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:______________

Physical work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:______________

Exercise: ❑ Heavy ❑ Moderate ❑ Light Hours per week:__________Type:______________

Smoking: ❑ Current ❑ Previous Packs/day:____________# of years:____________

Alcohol: Beer/week:____________Liquor/week:____________Wine/week:____________# of years:____________

Caffeine: Cups/day:____________# of years:____________

Aspirin: #/day:____________# of years:____________Others:______________

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Review of Systems

Check only the ones you **now** have or ones that you have had in the **past**:

General	NOW	PAST
Weakness	❑ N	❑ P
Fatigue	❑ N	❑ P
Fever	❑ N	❑ P
Chills	❑ N	❑ P
Night sweats	❑ N	❑ P
Fainting	❑ N	❑ P

Skin	NOW	PAST
Color changes	❑ N	❑ P
Nail changes	❑ N	❑ P
Hair changes	❑ N	❑ P
Moles	❑ N	❑ P
Rashes	❑ N	❑ P
Sores	❑ N	❑ P
Weakness	❑ N	❑ P

Head	NOW	PAST
Headaches	❑ N	❑ P
Injuries	❑ N	❑ P
Bumps	❑ N	❑ P
Last eye exam:________________________		
Glasses	❑ N	❑ P
Contacts	❑ N	❑ P
Cataracts	❑ N	❑ P

Ears	NOW	PAST
Hard of hearing	❑ N	❑ P
Deafness	❑ N	❑ P
Ringing	❑ N	❑ P
Discharge	❑ N	❑ P
Earache	❑ N	❑ P
Itching	❑ N	❑ P
Dizziness	❑ N	❑ P
Room spins	❑ N	❑ P

Nose	NOW	PAST
Decreased smell	❑ N	❑ P
Bleeding	❑ N	❑ P
Pain	❑ N	❑ P
Discharge	❑ N	❑ P
Obstruction	❑ N	❑ P
Post nasal drip	❑ N	❑ P
Deviated septum	❑ N	❑ P
Runny nose	❑ N	❑ P
Sinus congestion	❑ N	❑ P

Mouth	NOW	PAST
Bleeding gums	❑ N	❑ P
Sores	❑ N	❑ P
Dental problems	❑ N	❑ P
Bad breath	❑ N	❑ P
Loss of taste	❑ N	❑ P
Dry mouth	❑ N	❑ P
Ulcers	❑ N	❑ P
Blisters	❑ N	❑ P

Throat	NOW	PAST
Soreness	❑ N	❑ P
Bad tonsils	❑ N	❑ P
Hoarseness	❑ N	❑ P
Pain	❑ N	❑ P
Trouble swallowing	❑ N	❑ P
Recurrent infections	❑ N	❑ P

Neck	NOW	PAST
Neck enlargement	❑ N	❑ P
Stiff neck	❑ N	❑ P
Soreness	❑ N	❑ P
Lumps	❑ N	❑ P
Masses	❑ N	❑ P

Breasts	NOW	PAST
Discharge	❑ N	❑ P
Lumps	❑ N	❑ P
Pain	❑ N	❑ P
Bleeding	❑ N	❑ P
Nipple changes	❑ N	❑ P
Skin changes	❑ N	❑ P
Bloated	❑ N	❑ P

Lungs	NOW	PAST
Cough	❑ N	❑ P
Phlegm	❑ N	❑ P
Blood	❑ N	❑ P
Short of breath	❑ N	❑ P
Wheezing	❑ N	❑ P
Pain	❑ N	❑ P
Congestion	❑ N	❑ P
Inhalant exposure	❑ N	❑ P

Heart	NOW	PAST
Murmur	❑ N	❑ P
Palpitations	❑ N	❑ P
Rapid heartbeat	❑ N	❑ P
Swollen extremities	❑ N	❑ P
Cold extremities	❑ N	❑ P
Chest pain/pressure	❑ N	❑ P
Varicose veins	❑ N	❑ P
Blood clots	❑ N	❑ P
Blue extremities	❑ N	❑ P

Blood	NOW	PAST
Anemia	❑ N	❑ P
Low blood iron	❑ N	❑ P
Easy Bruising	❑ N	❑ P
Easy bleeding	❑ N	❑ P
Swollen nodes	❑ N	❑ P
Painful nodes	❑ N	❑ P
Sugar in blood	❑ N	❑ P
Red spots	❑ N	❑ P

Gastrointestinal	NOW	PAST
Abdominal pain	❑ N	❑ P
Nausea	❑ N	❑ P
Bloated	❑ N	❑ P
Belching	❑ N	❑ P
Heartburn	❑ N	❑ P
Indigestion	❑ N	❑ P
Irregular bowel habits	❑ N	❑ P
Constipation	❑ N	❑ P
Diarrhea	❑ N	❑ P
Gas	❑ N	❑ P
Hemorrhoids	❑ N	❑ P
Poor appetite	❑ N	❑ P
Food intolerance	❑ N	❑ P
Bloody stools	❑ N	❑ P
Black stools	❑ N	❑ P

Genitourinary	NOW	PAST
Urgency	❑ N	❑ P
Incontinence	❑ N	❑ P
Straining	❑ N	❑ P
Back pain	❑ N	❑ P
Frequent Vomiting	❑ N	❑ P
Stones	❑ N	❑ P
Burning	❑ N	❑ P
Bed wetting	❑ N	❑ P
Small stream	❑ N	❑ P
Discharge	❑ N	❑ P
Impotence	❑ N	❑ P
Dribbling	❑ N	❑ P
Cloudy urine	❑ N	❑ P
Menstrual cramps	❑ N	❑ P
Irregular periods	❑ N	❑ P
Hot flashes	❑ N	❑ P

Contraception type:________________
# of pregnancies:________________
# of births:________________
# of miscarriages:________________
# of abortions:________________
Menstrual flow: ❑ Heavy ❑ Mod ❑ Light
Last period:________________
Last pap smear:________________
Last vaginal exam :________________
Last mammogram:________________
Last prostate exam:________________

Musculoskeletal	NOW	PAST
Muscle pain	❑ N	❑ P
Muscle weakness	❑ N	❑ P
Muscle cramps	❑ N	❑ P
Muscle twitching	❑ N	❑ P
Joint stiffness	❑ N	❑ P
Joint pain	❑ N	❑ P

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Review of Systems (continued)

Check only the ones you **now** have or ones that you have had in the **past**:

Neurologic	NOW	PAST
Seizures	❑ N	❑ P
Vertigo	❑ N	❑ P
Dizziness	❑ N	❑ P
Hand trembling	❑ N	❑ P
Loss of sensation	❑ N	❑ P
Incoordination	❑ N	❑ P
Loss of facial control	❑ N	❑ P
Weak grip	❑ N	❑ P
Paralysis	❑ N	❑ P
Difficult speech	❑ N	❑ P
Tingling	❑ N	❑ P
Loss of memory	❑ N	❑ P
Numbness	❑ N	❑ P
Endocrine	**NOW**	**PAST**
Weight loss	❑ N	❑ P
Weight gain	❑ N	❑ P
Extremely thin	❑ N	❑ P
Heat intolerance	❑ N	❑ P
Cold intolerance	❑ N	❑ P
Hair changes	❑ N	❑ P
Breast changes	❑ N	❑ P
Psychiatric	**NOW**	**PAST**
Hyperventilation	❑ N	❑ P
Insecurity	❑ N	❑ P
Depression	❑ N	❑ P
Troubled sleep	❑ N	❑ P
Irritable	❑ N	❑ P
Undecidedness	❑ N	❑ P
Timid	❑ N	❑ P
Hallucinations	❑ N	❑ P
Loss of memory	❑ N	❑ P
Alcoholism	❑ N	❑ P
Drug addiction	❑ N	❑ P
Drug dependent	❑ N	❑ P
Suicidal thoughts	❑ N	❑ P
Extreme worry	❑ N	❑ P

Past Medical History *Check only the ones you have had in the* ***past****.*

Hay fever	❑ Y	Parasites	❑ Y
Mumps	❑ Y	Epilepsy	❑ Y
Rheumatic fever	❑ Y	Paralysis	❑ Y
Allergies	❑ Y	Polio	❑ Y
Angina	❑ Y	Mental illness	❑ Y
Cancer	❑ Y	Alcoholism	❑ Y
Tumor	❑ Y	Depression	❑ Y
Blood disease	❑ Y	Nervous breakdown	❑ Y
Leukemia	❑ Y	Migraine	❑ Y
Heart trouble	❑ Y	Gout	❑ Y
Varicose veins	❑ Y	Hemorrhoids	❑ Y
Phlebitis	❑ Y	Prostate problems	❑ Y
Hypertension	❑ Y	Sexual problems	❑ Y
Stroke	❑ Y	Gonorrhea	❑ Y
Ulcers	❑ Y	Syphilis	❑ Y
Jaundice	❑ Y	Diabetes	❑ Y
Skin trouble	❑ Y	Bladder trouble	❑ Y
Gallstones	❑ Y	Kidney stones	❑ Y
Liver trouble	❑ Y	Kidney infections	❑ Y
Hepatitis	❑ Y	Dysentery	❑ Y

Allergies *Please list any allergies you have.*

____

____

____

Medications *Please list any medications you are taking.*

____

____

____

I, the undersigned, whose name appears on page 1 of this patient in-take form, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the attending physician.

I authorize payment of any medical benefits from my insurance company to be paid directly to Full Motion Life & Sport PLLC for any service rendered to me.

Patient Signature:______________________________Date:______________