Flag City Sport & Spine
643 Trenton Ave
Findlay, OH 45840
Chris Lofquist DC

# CASE HISTORY

Phone:419-427-6300 Fax:427-2588

FULL NAME: _____DATE: _____CASE#: _____

## History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaint(s).

1. _____How long? _____
2. _____How long? _____
3. _____How long? _____
4. _____How long? _____

What words best describe your present condition(s)? (ex. ache, burn)_____

Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe)

0 1 2 3 4 5 6 7 8 9 10

When is your condition most severe? _____
When is your condition least severe? _____
What makes your condition feel worse? _____
What makes your condition feel better? _____
What activities are difficult because of your condition(s)? _____
Have you seen any other health care provider for your present condition? ☐ YES ☐ NO
Who? _____
Current Medications_____

Are you or could you be pregnant? ☐ YES ☐ NO

Are you experiencing or do you have any of the following?

| | | |
|---|---|---|
| ☐ A sore that won't heal | ☐ Difficulty swallowing | ☐ Persistent cough/hoarseness |
| ☐ Any bleeding/discharge | ☐ Lump/thickening anywhere | ☐ Wart/ mole changes |
| ☐ Bladder/bowel problems | ☐ Night pain | ☐ Weight loss without trying |
| | | ☐ **None of the above** |

## Review of Systems

In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?

**Neuromusculoskeletal System**

| | | | |
|---|---|---|---|
| ☐ Anxiety | ☐ Facial drooping | ☐ Loss of balance | ☐ Seizures |
| ☐ Atrophy | ☐ Headache | ☐ Memory loss | ☐ Sensory changes |
| ☐ Concussion | ☐ Joint deformity | ☐ Mood swings | ☐ Speech problems |
| ☐ Depression | ☐ Joint locking | ☐ Muscle weakness | ☐ Stiffness |
| ☐ Difficulty walking | ☐ Joint swelling | ☐ Numbness | ☐ Tremors |
| ☐ Dizziness | ☐ Lack of coordination | ☐ Popping noises | ☐ Twitches |
| ☐ Extremity deformity | ☐ Limited range of motion | ☐ Psychiatric disorders | ☐ Vision trouble |
| | | | ☐ **None of the above** |

**Cardiovascular System**

| | | | |
|---|---|---|---|
| ☐ Ankle swelling | ☐ Chest pain | ☐ Jaw pain | ☐ Pin stroke |
| ☐ Blood clots | ☐ Dizziness | ☐ Known vascular disease | ☐ Previous stroke |
| ☐ Carotid blockage | ☐ Fainting | ☐ Mitral valve prolapse | ☐ Shortness of breath |
| ☐ Changes in skin color | ☐ Hypertension | ☐ Phlebitis | ☐ Varicose veins |
| | | | ☐ **None of the above** |

## Past History

List any surgeries you have had (including appendix, tonsils, wisdom teeth)

1. _____Date_____ 3. _____Date_____
2. _____Date_____ 4. _____Date_____

Have you ever been hospitalized for anything in addition to surgeries? ☐ YES ☐ NO
If so, when and for what reason? _____
Have you ever been diagnosed as having a particular condition? (diabetes, heart trouble, cancer)
☐ YES ☐ NO _____
Are you currently under a doctors care for conditions other than the ones you are seeking care for?
☐ YES ☐ NO _____