Dynamic Chiropractic

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Patient History Should Precede Examination

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Editor's note: Dr. Miller is the author of *Practical Assessment of the Chiropractic Patient*.

When I was in chiropractic college, some weeks were filled with endless lectures about the signs and symptoms of numerous conditions. At times, it all seemed to be a jumbled mass; the signs and symptoms of many of these conditions were often variable or overlapping, and rarely were they pathognomonic. I used to worry that once in practice I would not be able to recognize a set of signs and symptoms as a specific disease, especially since patients with many of these conditions are not seen in a chiropractic office on a weekly or even yearly basis. In other words, patients with spinal cord tumors and Charcot Marie-Tooth syndrome don't walk in very often.

Now, after 14 years of practice, I look back and realize that worrying over this was a good thing. It kept me on my toes those first few years. I also realize I have done a better job of recognizing many of the variable and rare conditions than I thought I would. I attribute this to being vigilant and taking a good case history. While there are many aspects of history taking, the two most important items are asking the right questions, and knowing the signs and symptoms of what can be treated by chiropractic. You should know what you can treat as well as you know your own name.

The majority of the "right questions" are acquired in chiropractic school. However, many of the subtle questions, the ones that fine-tune history taking, can only be obtained through experience. Once the right questions are known, you must become consistent in asking them. The best way to be consistent is to use a good case history form with every patient. Obviously, no form can contain every possible question, but there are forms that are much better than others. History forms can be completed by the patient, office personnel, a doctor or a combination of these. The process is noninvasive and can be efficient if organized properly.

"If I see another patient with the same old back and neck pain, I'm going to scream." I have made this statement, and I have heard other chiropractors say the same thing. While such conditions are our bread and butter, treating them can be monotonous. On the brighter side, after seeing hundreds of patients with the same old back and neck pain, you know the story so well that a patient with a different story really stands out. Motivational speaker Zig Ziglar speaks the truth when he says, "Repetition is the mother of all learning."

The two history skills described above are not independent; they must occur simultaneously. A good question to ask is, "Does your pain wake you at night?" A "yes" answer is usually considered an ominous sign, as mechanical pain is usually relieved by rest, while disease such as infection or tumors often cause unremitting pain. However, patients lie in awkward positions and move in their sleep. Patients with sore hips or shoulders eventually wake up with pain when they find themselves lying on their sides and causing their sore joints to bear weight; patients with knee, elbow or spine pain may move suddenly during sleep, causing pain or spasm. Thus, these follow-up questions must be asked:

- "Were you lying on your shoulder or hip when you awoke with the pain?"
- "Does the pain occur when you move or change positions?"
- "Does the pain wake you when you are lying perfectly still?"

Knowing these questions and understanding the differences in night pain have helped me identify several cases of metastatic disease. Examination textbooks often credit the case history with being responsible for 70 to 90 percent of the information needed to make a proper diagnosis. This is true. Headaches are a good example of this: migraine; tension; cervicogenic; cluster; and other types of headaches are diagnosed primarily by history. Unfortunately, some chiropractors skip over the case history or do a cursory job to get to the "hands-on" portion of the examination. Patients often report the opposite of this from our medical counterparts. "He sat across the room from me asking questions and never touched me," is a common patient complaint. Developing a happy medium is vital to proper patient evaluation.

Every case is built upon the foundation of a good case history. History precedes examination; history and examination precede radiographs and other imaging studies; orderly evaluation determines diagnosis and treatment; and the patient response to care determines continuation, alteration or termination of care. The logic of this disorder should not be disturbed.

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