CASE NO. ____________

CONFIDENTIAL CASE HISTORY RECORD

Please fill out the following form in as much detail as possible.
Please Print

Date ____________

Name ______________________ SS# ____________

Address ______________________

City ______________________ State ______ Zip ____________

Home Phone ____________ Work # ____________ Cell # ____________

Date of Birth ____________ Sex ❑ M ❑ F Referred by ____________

Occupation/Job ______________________

Employer ____________ Address ____________

Marital Status ❑ M ❑ S ❑ W ❑ D Children ______ Name of Spouse ____________

Is any other member of your family being treated in this office? ____________

Have you ever had chiropractic care before?______ Where? ____________

For what problem? ______________________

Were the results satisfactory? ❑ Yes ❑ No

Major complaints and symptoms - please be as specific as you can. Ask the doctor or nurse for help if you need assistance in filling out this section.

____

____

____

____

____

____

How do you believe your problem (pain) began? ____________

____

____

____

When did you first notice this problem/pain? ____________

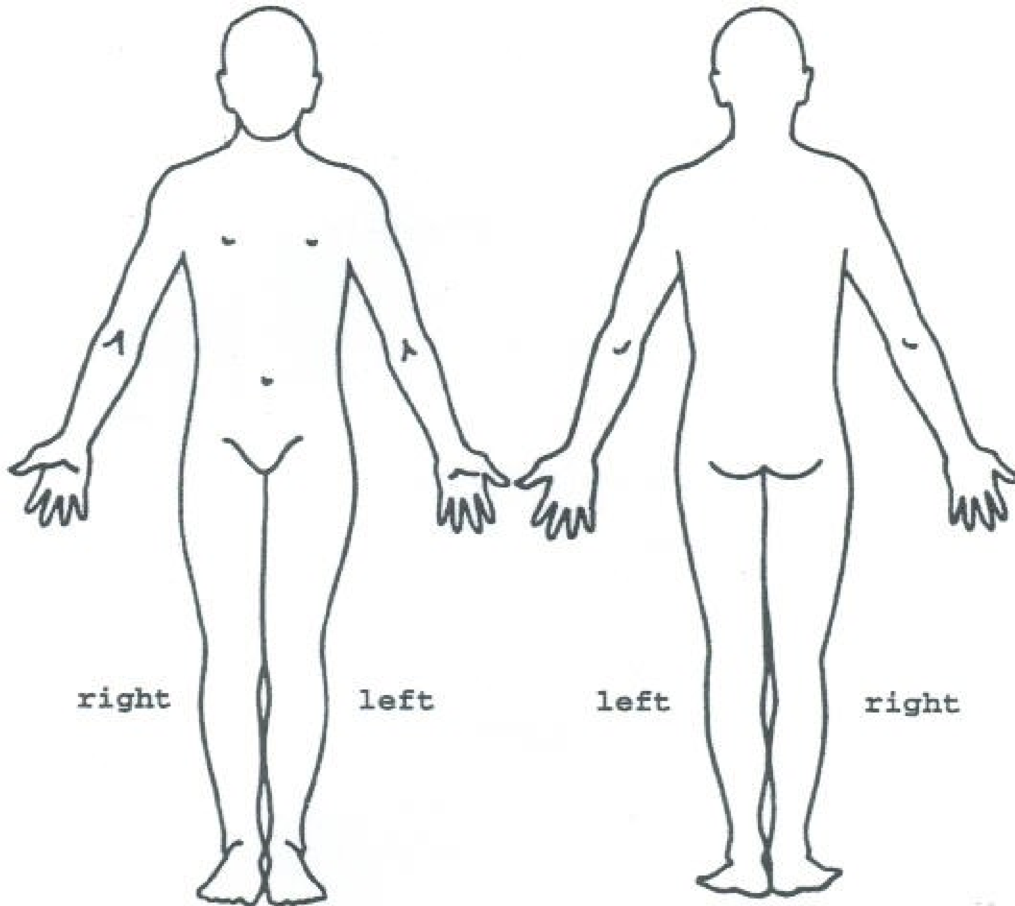
Have you lost any work? ____________ Day and date you last worked ____________

PAIN CHART

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas where the pain radiates - include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	zzzzz	/ / / / /
- - - - -	00000	xxxxx	zzzzz	/ / / / /
- - - - -	00000	xxxxx	zzzzz	/ / / / /



RATE YOUR PAIN: 0 = NO PAIN 10 = MOST INTENSE PAIN IMAGINABLE

1. At its worst 0 1 2 3 4 5 6 7 8 9 10
2. Right now 0 1 2 3 4 5 6 7 8 9 10
3. At its best 0 1 2 3 4 5 6 7 8 9 10

Have you ever had this condition before or a similar condition?______ When? ________________

What positions or activities aggravate your condition? ________________________________

What positions or activities relieve your condition? __________________________________

Have you been treated by a Medical Physician for this ailment?______ Where? ________________

Describe the type of treatment ____

Diagnosis of previous physician ____

Length of time under care ________________ Results __________________________________

Family History: List any immediate family member who has had any of the following:
Enter (M) - Mother; (F) - Father; (B) - Brother; (S) - Sister

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Asthma
( ) Seizures
( ) Diabetes
( ) Circulation Problems
( ) Kidney Disease
( ) Stroke
( ) Arthritis
( ) Mental Illness
( ) Cancer
( ) Thyroid Disease
( ) Colitis

Family physician's name ______________________________

Emergency Contact ______________________ Phone ______________

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)? ____

When? ______________________________

Are you allergic to anything you are aware of? ______________________________

Are you presently taking any medication (aspirin included)? ❑ Yes ❑ No

If Yes, name them ______________________________

Have you ever broken any bones? (fractures)? ____________ Any dislocations? ____________

What operations have you had? ______________________ Year ________

______________________ Year ________

______________________ Year ________

Give dates you have had any of the following? (if exact date unknown, give approximate date)

Blood tests ______________________ MRI or CT Scan ______________

X-ray examination ______________________ Bone Scan ______________

At what hospital or office were these tests taken? ______________________________

Name of doctor who ordered tests ______________________________

Date of last menstrual period ______________________________

Do you have any reason to believe that you may be pregnant? ❑ Yes ❑ No

Do you have any health problems not listed above? ______________________________

Have you ever had cancer? ❑ Yes ❑ No Where? ______________________

Does your pain wake you from a sound sleep? ❑ Yes ❑ No

Have you lost or gained weight in the past year? ❑ Yes ❑ No

Habits: (please check)

- ❑ Cigarettes? Quantity ________
- ❑ Coffee? Quantity ________
- ❑ Alcohol? Quantity ________
- ❑ Tea? Quantity ________

Activities/Hobbies ____________________

____

Please list any vitamins you take ____________________

____

Use this space for any additional information you may wish to discuss ____________________

____

____

____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you. Please check the now or past column if it applies to you.

	Now	Past		Now	Past		Now	Past
Headaches	___	___	Loss of Memory	___	___	High Blood Pressure	___	___
Neck Pain	___	___	Chest Pains	___	___	Cold Hands	___	___
Mid Back Pain	___	___	Shortness of Breath	___	___	Cold Feet	___	___
Low Back Pain	___	___	Allergies	___	___	Leg Cramps	___	___
Arm/Hand Pain	___	___	Hay Fever	___	___	Fever	___	___
Arm/Hand Numbness	___	___	Frequent Colds	___	___	Night Sweats	___	___
Arm/Hand Weakness	___	___	Sinus Problems	___	___	Stomach Upset	___	___
Leg/Foot Pain	___	___	Arthritis	___	___	Indigestion	___	___
Leg/Foot Numbness	___	___	Swollen Joints	___	___	Belching	___	___
Leg/Foot Weakness	___	___	Muscle Spasms	___	___	Vomiting	___	___
Fainting	___	___	Nervousness	___	___	Diarrhea	___	___
Dizziness	___	___	Tension	___	___	Constipation	___	___
Loss of Balance	___	___	Irritability	___	___	Colitis	___	___
Ringing in Ears	___	___	Fatigue	___	___	Hemorrhoids	___	___
Blurred Vision	___	___	Depression	___	___	Difficulty Urinating	___	___
Loss of Smell	___	___	Sleeping Problems	___	___	Gall Bladder	___	___
Loss of Taste	___	___	Menstrual Difficulties	___	___	Diabetes	___	___

I understand that a complete and accurate case history is necessary in order for the Doctor to provide the most appropriate treatment. I hereby acknowledge that the above information is accurate and complete to the best of my knowledge and recollection, and that I haven't knowingly omitted any information in regard to my medical history.

PATIENT'S SIGNATURE ____________________ DATE ________

PLEASE PRINT NAME ____________________