CHIROPRACTIC CASE HISTORY

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date:_____

Name:_____Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____Work Phone: _____E-mail_____
Social Security #:_____Age:_____ ❑ Male ❑ Female
Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____
Name of Spouse or Nearest Relative:_____ Phone:_____
Your Occupation_____ Your Employer:_____
Referred to this Office by: ❑Friend/Family Member - Name?_____
❑ Website_____ ❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other_____
Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance
❑Automobile Insurance ❑Worker's Compensation
Name of Insurance Co.:_____Insured's Employer: _____
Insured's Social Security #:_____ Employer's Phone #:_____
Are you covered by more than one insurance company? ❑Yes ❑No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which **PAST** conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble	❑	❑	❑	diabetes
❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis	❑	❑	❑	indigestion
❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal dx				

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____
Name and location of Doctor _____
May we contact your primary doctor? _____
Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

ACCIDENT HISTORY:

❑Job ❑Auto ❑Other 1. _____ Date:_____
❑Job ❑Auto ❑Other 2._____Date:_____
❑Job ❑Auto ❑Other 3._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate each symptom 1 - 10 (with 1 being extremely minor, 10 being extremely painful)

Symptom **Rate**

A. _____ _____

B. _____ _____

C. _____ _____

D. _____ _____

1. SYMPTOMS ARE WORSE IN: ❑MORNING ❑AFTERNOON ❑NIGHT
2. WHEN AND HOW OCCURRED?_____

_____

3. SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED:_____
4. SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

5. SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

6. DESCRIBE THE PAIN: SHARP _____ DULL_____ BURNING _____ STABBING _____
NUMBNESS _____ TINGLING_____ ACHING _____ OTHER _____

7. HAVE YOU EVER HAD THIS BEFORE? ❑NO ❑YES ; WHEN?_____

8. IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____ _____

9. NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

10. ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑NO ❑YES; WHAT KIND?_____

_____

11. ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES; WHAT KIND?_____

_____

12. ARE YOU PREGNANT? ❑NO ❑YES; DATE OF LAST MENSTRUAL PERIOD:_____

13. PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

14. PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN❑TURNING HEAD
❑REACHING❑WALKING ☐STRETCHING

15. PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss/confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Guardian's Signature Authorizing Care_____ Date: _____

Patient's Signature:_____ Date:_____