Chiropractic Case History/Patient Information

Date_____

Name_____ Home Phone_____

Address _____ City _____ State_____ Zip _____

E-mail address:_____Work/CellPhone_____

Age_____ Birth Date _____ Marital: S M D W How many children?_____

Occupation_____Employer_____

Student at_____ Full Time _____Part Time _____

Spouse _____Occupation _____Employer_____

Emergency Contact_____ Address_____Phone_____

Referred by: _____

Is the condition due to injury or sickness arising out of employment? _____

Is the condition due to injury or sickness arising out of auto or other accident? _____

Date symptoms appeared or accident happened _____ Number of days lost from work_____

Have you ever had the same or a similar condition? Yes____ No ___ If yes, when and describe:_____

_____

Date of last physical examination_____What surgeries have you had? (Include dates) _____

_____

Serious illnesses (include dates)_____

_____

Have you ever suffered from: (Please check the conditions that apply)

___ Dizziness	___ Headaches	___ Sinus Trouble
___ Fainting	___ Heart Trouble	___ Anemia
___ Visual disturbances	___ Diabetes	___ Rheumatic Fever
___ Difficulty speaking	___ Hernia	___ Cancer
___ Difficulty swallowing	___ Arthritis	___ Hormone Problems
___ Difficulty walking	___ Asthma	___ HIV
___ Nausea	___ Neuritis	___ Hepatitis
___ Numbness	___ Digestive Disorders	
___ Backaches	___ Nervousness	

Purpose of this appointment: _____

Have you been treated for any health condition by a physician in the last year? Yes___ No___

If yes, describe:_____

Medications you now take: ___ Antidepressants ___Thyroid ___ Painkillers/Anti-inflammatory

___ Blood Pressure ___ Birth Control ___ None ___Other_____

Please list any herbal or nutritional supplements you are currently taking. _____

_____

Have you previously received chiropractic care? ___Yes ___No How long ago? _____

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____

   _____
3. When was the first time you noticed this problem? _____

   How did it originally occur? _____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only _____

   With activity_____ How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other _____
6. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____

   _____. If no, what have you tried to do that has not helped? _____

   _____
7. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

   Lifting _____ Twisting _____ Other _____
8. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes _____ No _____. If yes, describe _____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

   _____
9. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____

   _____
10. List any major accidents you have had other than those that might be mentioned above: _____

    _____
11. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____

    _____
12. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____ Due Date _____
13. Remarks: _____

    _____

    _____

NO SYMPTOMS |_____| EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

I understand that my care in this office may involve the making of judgments that are based upon facts known by the doctor. Therefore, the above information is true to the best of my knowledge. I understand that the practice of any healing art is not an exact science and that no guarantee of results will be made by the doctor or staff.

PATIENTS SIGNATURE _____ DATE _____