

Case History



Name _____ Date _____ S.S. # _____

Street _____ City _____ State _____ Zip _____

H. Phone _____ W. Phone _____ Birth Date _____ Age _____ Sex: M F

If female, is there a possibility that you might be pregnant? YES NO Marital Status: M S W D No. of children _____

E-mail address: _____

Occupation _____ Employer _____

Spouse's Name _____ Spouse's Employer/Occupation _____

Who should we call in an emergency? Name _____ Phone _____

List any surgeries (include date) _____

Previous Injuries: _____

- | | | | | | |
|--------------------------|--------------------------|-----------------------------------------------------------------|--------------------------|--------------------------|------------------------------------------------------|
| Yes | No | Health Habits | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink 2 or more alcoholic beverages each day? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you maintain a good posture? | <input type="checkbox"/> | <input type="checkbox"/> | Do you take nutritional supplements? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise regularly? | <input type="checkbox"/> | <input type="checkbox"/> | Do you consider yourself to be healthy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you eat 5 or more servings of fruits or vegetables each day? | <input type="checkbox"/> | <input type="checkbox"/> | Do you frequently feel emotionally stressed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? | | | |

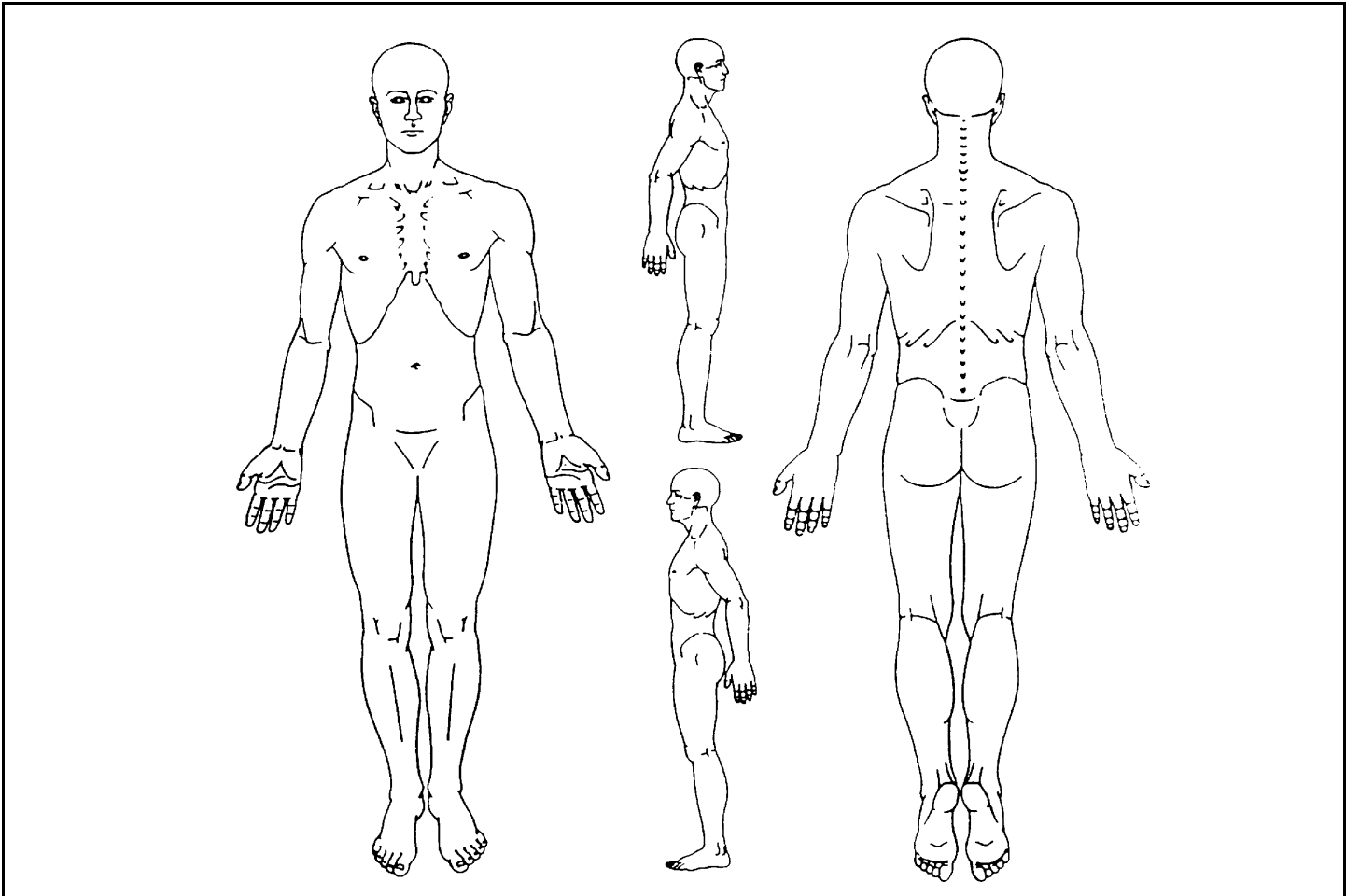
In the following list, please check all of the conditions that you have experienced in the past year.

- | | | | |
|------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------|
| HEAD | <input type="checkbox"/> Numbness or tingling in hands | <input type="checkbox"/> Pain in hip joint | <input type="checkbox"/> Difficulty starting urination |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Loss of strength in arms | <input type="checkbox"/> Pain down upper leg | <input type="checkbox"/> Night urination |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Loss of strength in hands | <input type="checkbox"/> Pain down below knee | GENERAL |
| <input type="checkbox"/> Head feels heavy | BACK | <input type="checkbox"/> Pain in both legs | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Numbness or tingling in legs | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Pain when breathing | <input type="checkbox"/> Numbness or tingling in toes | <input type="checkbox"/> Fatigue |
| NECK | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Neck pain | ABDOMEN - DIGESTION | WOMEN ONLY | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Grinding sounds in neck | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Cancer |
| SHOULDERS | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cramping | <input type="checkbox"/> Breathing problems |
| <input type="checkbox"/> Pain in shoulders | <input type="checkbox"/> Constipation | <input type="checkbox"/> Irregularity | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Can't raise arm | <input type="checkbox"/> Heart burn | <input type="checkbox"/> Menopause | <input type="checkbox"/> Allergies |
| ARMS & HANDS | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Pre-menstrual Syndrome | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Pain in arm | HIPS, LEGS & FEET | MEN ONLY | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pain in hands | <input type="checkbox"/> Pain in buttocks | <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Numbness or tingling in arm | | | <input type="checkbox"/> Difficulty losing weight |

Other problems: _____



In the box below, please mark the areas of pain or other symptoms.



Have you ever received Chiropractic care? Y / N If yes where? _____

List other doctors consulted for present complaints:

Name _____ When _____ Diagnosis _____ Treatment _____

Name _____ When _____ Diagnosis _____ Treatment _____

Drugs you now take: _____

Informed Consent: The role of a chiropractor is to help restore function to the spine through chiropractic adjustments. As this is done, most patients experience improvement in spine related conditions. The speed or extent of improvement is to a large degree dependent upon the inherent recuperative abilities of each patient. Some experience very rapid results, some slower results. A small percentage receive no outward benefit. Chiropractic does not treat pain, although most patients do experience reduced pain. Occasionally some patients experience a short-term increase in pain. As with any health care procedure, chiropractic adjustments have some risk. Increased risk often results from some underlying weakness or condition possessed by the patient that is not readily apparent through routine examination. Serious complications to chiropractic adjustments are considered by most authorities to be very rare, occurring once per one million adjustments. By individuals not properly trained, such as lay people and most medical physicians, the risk can be much greater. When evaluating risks and benefits of health care procedures, you must consider the risk of not receiving care. Left untreated, spine function usually deteriorates. Patients who choose medical care rather than chiropractic choose to accept the even greater risks associated with medical care. Prescription drugs cause over 100,000 deaths each year. Over-the-counter drugs also have a poor safety record. Surgery has risks hundreds and even thousands of times greater than chiropractic. Most experts and chiropractic patients agree that the benefits of chiropractic far outweigh the risks, however there are some risks. By signing below you acknowledge that you understand this and agree to continue with your care.

Patient's signature

Date

Referred by: _____

Payment Type: _____

In the next box, describe your major complaint

Complaint _____

When did this problem start or when did the most recent occurrence start if you have had it before:

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint. A "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

How often do you feel symptoms: Constant, or _____ X per day, week, month, year.

Have you had similar symptoms in the past? Yes No _____

What activities aggravate this condition _____

Is this condition getting worse? Yes No _____

Is this condition interfering with your: work sleep daily routine Other _____

Notes _____

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If you have a second major complaint please describe it in the next box

Complaint _____

When did this problem start or when did the most recent occurrence start if you have had it before:

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint. A "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

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