

CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION

DATE: _____

First Name _____ Middle Initial _____ Last Name _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Cellular phone # _____ e-mail address _____
Age _____ Birth Date ____/____/____ Marital Status: M S W D How Many Children? _____ Ages: _____
Occupation _____ Employer _____ How Long? _____ Office Phone # _____
Name of Spouse _____ His/Her Occupation _____ Office Phone # _____
Name of Nearest Relative not living with you _____ Phone # _____

Who referred you to our office? _____

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? _____
Days lost from work? _____ Date symptoms appeared or accident happened _____
Have you ever had the same or a similar condition? No Yes If yes, when and describe: _____

Date of last physical examination _____
What operations have you had? _____ When? _____
Serious Illnesses? _____ When? _____
Name of Primary Medical Physician _____

Have you ever suffered from:

Dizziness	Arthritis	Digestive Disorders	Low Back Pain
Heart Trouble	Nervousness	Diabetes	Headaches
High Cholesterol	Asthma	Osteopenia/Osteoporosis	Mid Back Pain
Stroke	Hernia	Foot Trouble	Tingling in Arms/Legs
High Blood Pressure	Cancer	Trouble Sleeping	Neck Pain
HIV/AIDS	Kidney Problems	Prostate Problems	Other, describe: _____

Have you ever seen a chiropractor? No Yes - when and why? _____
Your reason for *this* visit: _____
Other doctors seen for this condition: _____
Have you been treated for *any* health condition by *any* physician in the last year? No Yes- describe _____

What medications or drugs are you currently taking and why? _____

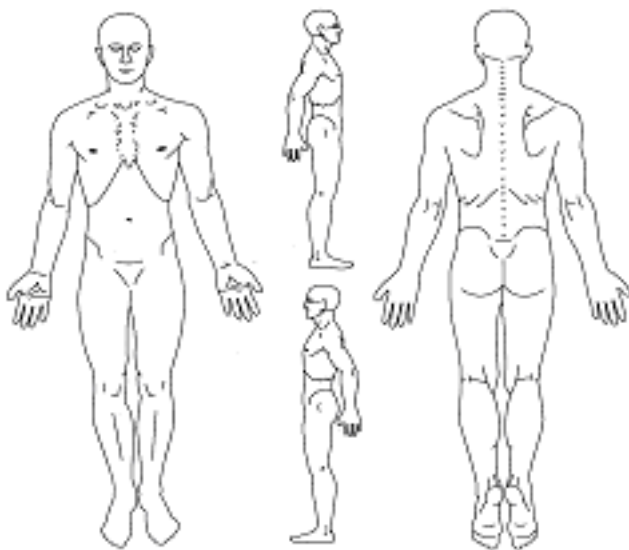
I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate and healthful treatment. If there is any change in my health status, I will inform the doctor.

I authorize my insurance company to pay this doctor/clinic all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor/clinic to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

1. What is your major symptom? _____
 2. If this is a recurrence, 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? _____
 3. How frequent is the condition? Constant Daily Intermittent Night Only
 How long does it last? All Day Few Hours Minutes
 4. Do you have any other conditions or symptoms that you feel may be related to your major symptom? No Yes
 If yes, describe: _____
 Are there other unrelated health problems? No Yes, describe _____
 5. Describe the pain. Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____
 6. Is there anything you can do to relieve the symptoms? 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. Have you had any broken bones? No Yes If yes, please list and give dates: _____
 9. List any major accidents you have had other than those that may be mentioned above. _____
-
10. To your knowledge, have you had any diseases, major illnesses, or injuries in the past or the present that are not indicated on this form? No Yes, describe: _____
11. **WOMEN ONLY:** Are you pregnant or is there any possibility that you may be pregnant? Yes No Uncertain
12. Please mark the location of your symptoms in the appropriate areas on the images below.



On the lines below, please draw a vertical line representing your pain / discomfort:

Rate the pain/symptoms you have right **now**:

_____ no symptoms unbearable symptoms

Rate your pain/symptoms at their **best** in the past week:

_____ no symptoms unbearable symptoms

Rate your pain/symptoms at their **worst** in the past week:

_____ no symptoms unbearable symptoms