



Chiropractic Case History

Today's Date ____/____/____

Name _____ Gender: Male / Female Age _____

Date of Birth ____/____/____ Height _____ Weight _____

Address _____

City _____ State _____ Zip _____

H. Phone(____) _____ Cell (____) _____ Text OK? Yes / No

Email _____ Are email appointment reminders OK? Yes / No

Preferred method of communication? _____ Referred by _____

Occupation _____ Employer _____

Have you ever received Chiropractic Care? Yes / No If yes, when? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint began when and how? _____

Please circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma (especially to the head or neck): _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication

Reason for taking

<u>Medication</u>	<u>Reason for taking</u>
_____	_____
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date

Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery

Outcome

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death

Age at death

6. Social and Occupational History:

A. Level of Education:

___ high school ___ some college ___ college graduate ___ post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____