

CONFIDENTIAL CASE HISTORY

Name _____ Date of Birth _____ Age _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Phone (Home) _____ Phone (Cell) _____ Email _____
 Sex: M/F Marital Status: S/M/D/W Ages of Children _____ Social Security # _____
 Occupation & Employer _____ Phone (Work) _____
 Spouse's Name _____ Spouse's Occupation _____
 Spouse's Employer _____ Spouse's Phone (Work) _____
 Emergency Contact: Name _____ Phone _____
 How were you referred to our office? _____

HEALTH REPORT:

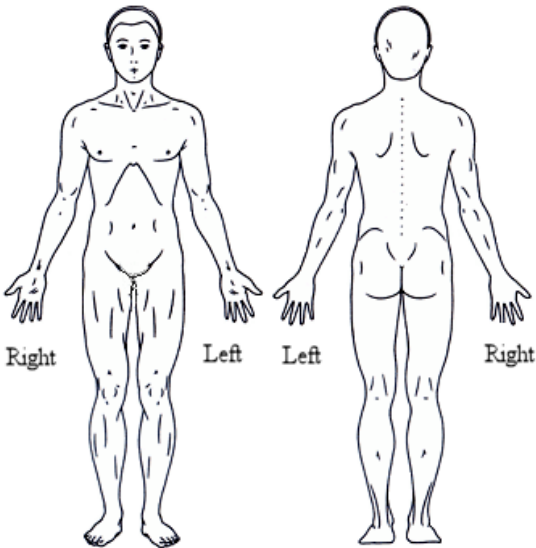
Primary reason for seeking care: _____
 Secondary reason for seeking care: _____
 List other doctors/practitioners seen for this: _____
 List diagnosis and type of treatment: _____
 Other things you have tried: _____
 Is present condition due to an injury? Yes/No: On the Job __ Auto Accident __ Other _____
 Has the accident been reported? Yes/No: To Employer __ Auto Carrier __ Other _____
 Have you had similar accidents or injuries before? Yes/No If yes, explain: _____
 List the names of any relatives that have or have had a similar problem: _____
 Have you received chiropractic treatment previously? Where/When: _____
 Date of last: X-ray _____ MRI/CT _____ Blood/Urine test _____ Other _____
 Have you been treated for any other health condition in the last year? Yes/No If yes, explain: _____

Medication _____	Dosage _____	Frequency _____	Condition _____
Medication _____	Dosage _____	Frequency _____	Condition _____
Medication _____	Dosage _____	Frequency _____	Condition _____

Have you taken other medications in the past? If yes, list medications _____

Surgery _____	Date _____	Condition _____
Surgery _____	Date _____	Condition _____

Vitamins/Supplements: _____



Please circle the **LEAST to MOST** levels of your usual daily experience of pain or discomfort below:
 (None) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)
 Using the symbols below, mark on the pictures where you feel pain or discomfort:

- Numbness = = =
- Dull Ache O O O
- Burning X X X
- Sharp/Stabbing // /
- Pins, Needles + + +
- Other ^ ^ ^

What aggravates your condition/pain? _____
 What lessens your condition/pain? _____
 Is this condition worse certain times of the day? Y/N: _____
 Is this condition interfering with Home? _____ Work? _____
 Sleep? _____ Recreation? _____ Other? _____
 Is this condition progressively getting worse? _____

FAMILY HISTORY: Health conditions, cause and age at death.

Father: _____
 Mother: _____
 Brother/s & Sister/s: _____

PERSONAL HABITS:

Do you smoke Y/N: #/day__ Alcohol Y/N: Daily __ Weekly __ Social Occasions__ Caffeinated drinks/day__
Hours of sleep per night: _____ Sleep Quality Scale: (None/Poor Sleep) 0 1 2 3 4 5 6 7 8 9 10 (Rested)
Hours of the day you spend: Sitting_____ Standing_____ Light Labor_____ Heavy Labor_____
Days a week you exercise 30 minutes or more: ___ Exercise Intensity: (Low) 0 1 2 3 4 5 6 7 8 9 10 (High)
Types of exercise: _____
Physical stress level: 0 1 2 3 4 5 6 7 8 9 10 (High). Emotional stress level: 0 1 2 3 4 5 6 7 8 9 10 (High)
List your major stressors: _____
What are you health goals? _____

Please mark each item below for each condition you have NOW (N) or had PREVIOUSLY (P):

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems R/L
- Leg Problems R/L
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones _____

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises (tinnitus)
- Hypo/Hyper Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Pain/Stones
- Hemorrhoids
- Liver problems
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection/Stones
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pre/Post menopausal
- Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____
Representative Signature (if minor) _____ Date _____