Please print off and bring with you to your appointment

Case History

Name ____

Sex [ ] Male [ ] Female

Date __________________________

Address ____City
__________________ State ______________ Zip

Referred by ____

Email ____

H. Phone (_______)___________________

C. Phone (_______)___________________

Date of Birth __________________________

Age __________________________

Occupation __________________________

Employer ____

Previous Chiropractic Care? [ ] Yes [ ] No

Acupuncture? [ ] Yes [ ] No

Nutrition? [ ] Yes [ ] No

Chief Complaint: ____

____

____

Location of Complaint ____

Complaint began when and how? ____

____

____

Please circle the Quality of the 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? ____________________

Previous treatments you've sought for your complaint: ____________________

Previous illnesses you've had in your life: ____________________

Previous injury or trauma: ____________________

Have you ever broken any bones? No If Yes, Which? ____________________

Medications:

Medication Reason for taking ______________________________

____

OVER Allergies ______________________________

____

Surgeries ______________________________

____

Year Type of Surgery ______________________________

____

Females/Pregnancies and outcomes ______________________________

____

Pregnancies/Date of Delivery Outcome ______________________________

____

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

____

Family Health History:

Associated health problems of relatives: ______________________________

____

Deaths in immediate family: ______________________________

Cause of parents or siblings death/Age at death ______________________________

____

Social and Occupational History:

Level of Education: [ ] High School [ ] Some College [ ] College Graduate [ ] Post Graduate Studies

Job description: ______________________________

____

Work schedule: ______________________________

____

Recreational activities: ______________________________

____

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 to provide me with health care, in accordance with this state's statutes.

______________________________	______________________________
Patient or Guardian Signature	Date

______________________________	______________________________
Doctor’s Signature	Date