CHIROPRACTIC CASE HISTORY

Name: ____ Sex: M / F Today's date: _______/______/_______

Address: ____ State: _________ Postcode: ____________

H. Phone: ____________________________ W. Phone: ___________________________ Mobile: _____________________________

Date of Birth: _________/______/_______ Age: _________ Occupation: ____

Email Address: ____

Referred by: ____ Health Insurance: ____________________________________

Have you ever received Chiropractic Care? Y / N If yes, when? ____

1. Primary reasons for seeking chiropractic care:

Location of complaint: ____

Complaint began when & 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? ____

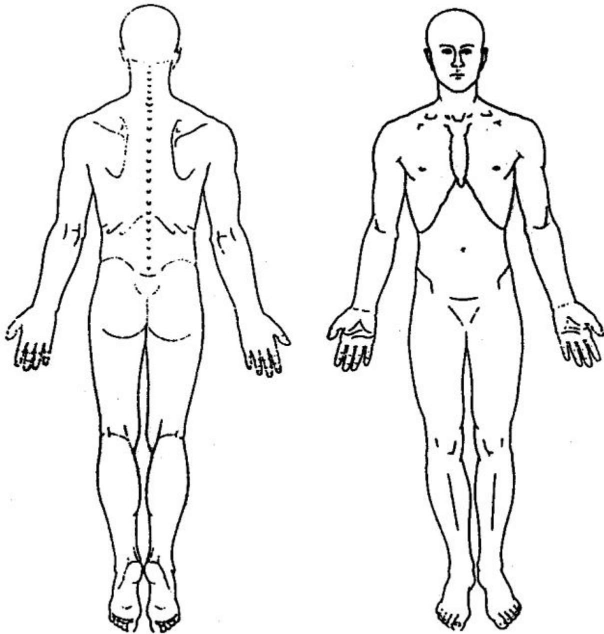
Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

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

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

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



XXX *Pain* **OOO** *Numbness/Pin & Needles*
(Mark areas)

Additional:____

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3. Past Health History:

A. Previous illnesses: ____

____

B. Previous injury or trauma: ____

____

Have you ever broken any bones? Which? ____

C. Allergies ____

D. Medications:

Medication	Reason for taking
____________________	____________________
____________________	____________________

E. Surgeries:

Type of Surgery:	Date:
____________________	____________________
____________________	____________________

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery:	Outcome:
____________________	____________________
____________________	____________________
____________________	____________________

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

4. Family Health History:

Associated health problems of relatives: ____

Deaths in immediate family:

Cause of parents or siblings death:	Age at death:
____________________	____________________
____________________	____________________

5. Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O 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: _______/_______/_______