# 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? _____

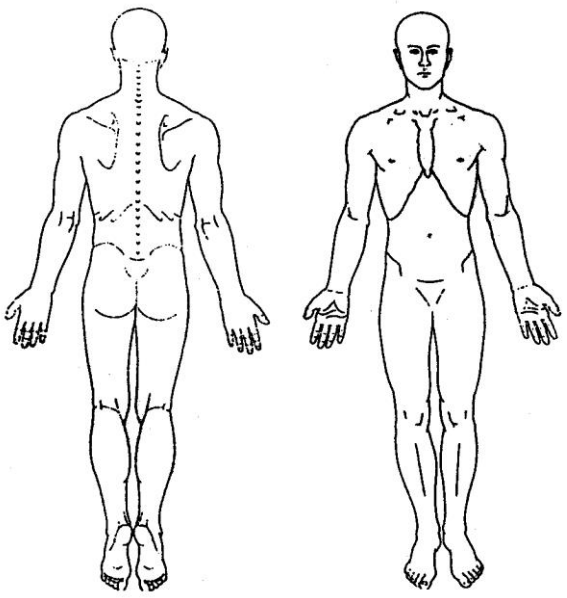
Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

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:** _____



**Additional:** _____

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

**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 authorise 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: ____/____/____