

CASE HISTORY

First Name _____ Mid Int. _____ Last Name _____ Nickname _____ Date: _____
 Address _____ City _____ State _____ Zip _____
 Patient SS# _____ Gender: M F Marital Status: S M D W Date Of Birth _____
 Spouse: _____ Children and Ages: _____
 E-mail Address: _____ Cell #: _____ Carrier: (for text msg.) _____
 H Ph: _____ W Ph: _____ Occupation: _____
 Employer: _____ Emergency Contact: (Name & PH #) _____
 Who may we thank for referring you to our office: _____ Visit due to a work or auto injury? Yes No

PRESENT STATE OF HEALTH

List complaints: List in order of severity.	How intense is it on scale of 0-10 (0 = No pain, 10 = worst pain ever)	How often does it bother you? 100%-75%-50%-25% of the time?
1. _____	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10 _	_____
2. _____	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10 _	_____
3. _____	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10 _	_____
4. _____	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10 _	_____

Please mark if you have any of the following health issues:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in Arms/hands | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Legs/feet | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Kidney Infections |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Pressure Hi/Lo |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Allergies | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Pins & Needles or Pn in Arms | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor Digestion | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Pins & Needles or Pn in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Eczema | <input type="checkbox"/> Frequent Colds |

Other complaints: _____

When did this condition first develop? _____ Has the problem been getting worse, better, or staying the same? _____

What caused this condition? _____ What have you done to help yourself? _____

PAST HISTORY

This is a **new/old** condition? I **have/haven't** had care for it before?

If previous care, what was done? _____

List surgeries: _____

Last time you had spinal x-rays or other x-rays: _____

Have you ever had Chiropractic Care before? Yes No

Name of Doctor: _____ When: _____

From Birth to Present, please list by date and describe:

Car accidents: _____

Falls/Injuries (including sports): _____

Other: _____

Is this visit related to a work injury or an automobile accident?

Yes

No

Unsure

Who may we thank for referring you to our office?
