

Chiropractic Case History

Name _____ Sex M F Married ___ Single ___ Divorced ___ Date _____

Address _____

State _____ Zip _____

H. Phone(_____) _____ W. Phone _____ Date of Birth _____

Age _____

Referred by _____ Social Security# _____

Occupation _____

Employer _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. Primary reasons for seeking chiropractic care:

Primary reason:

Secondary reason:

Other factors contributing to the primary and secondary reasons:

2. Chief Complaint:

Location of Complaint:

Complaint Began when and 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?

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

-

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which?

C. Allergies

D. Medications:

Medication

Reason for taking

E. Surgeries:

Date

Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery

Outcome

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

1. Family Health History:

Associated health problems of relatives:

Deaths in immediate family:

Cause of parents or siblings death

Age at death

2. Social and Occupational History:

A. Level of Education:

high school

some college

college graduate

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.

Parent or Guardian Signature

Date

Doctors Signature

Date