

CONFIDENTIAL PATIENT CASE HISTORY

Today's date _____

Name _____ name you prefer to be called _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ email _____

Occupation _____ Employer _____

Work Address _____ Work Phone _____

Birth date _____ Age _____ Male Female

Marital Status S M W D Spouse name _____

Emergency Contact _____ Relationship _____ Phone _____

Referred by _____

HEALTH INFORMATION

Have you had previous chiropractic care? Yes _____ No _____

What is your major complaint? What caused it? Describe the pain and its location.

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What aggravates your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with Work Sleep Daily Routine Other _____

How long has it been since you really felt good? _____

Other doctors who treated this condition _____

PAIN LEVEL: On a scale of 0-10, with 0 being pain free and 10 being you are in agony, where would you rate yourself?

0 1 2 3 4 5 6 7 8 9 10

Patient name _____

List surgical operations and year of occurrence: _____

List all drugs/medications/vitamin supplements you are currently taking: _____

List any allergies you have, including to medications: _____

Are you wearing _____ Orthotics _____ Heel Lifts _____ Arch Supports?

How old is your mattress? _____ How many pillows do you use? _____

Have you been in an auto accident? _____ If yes, when and describe: _____

Have you had any other personal injury or accident? _____ If yes, when and describe: _____

Primary Care Physician _____ Phone _____

Do you smoke? _____ Packs per day _____ for how long _____

Do you drink alcohol? _____ Drinks per week _____

Do you use caffeine? _____ Cups per day _____

Do you exercise regularly? _____ What type and how often? _____

During the day (work or home) do you mainly _____ sit at computer/desk, _____ stand in one position, _____ lift < 25 lbs., _____ lift > 25 lbs., _____ walk? Explain: _____

Have you ever suffered from?

Dizziness _____ Backaches _____ Heart trouble _____ Diabetes _____

Arthritis _____ Headaches _____ Asthma _____ Digestive disorders _____

Nervousness _____ Sinus trouble _____ Neck pain _____

FAMILY MEDICAL HISTORY: Has any family member (parents, siblings, grandparents) had any of the following disorders: (Please list their relationship to you next to disorder.)

High blood pressure _____ Heart disease _____

Cancer _____ Diabetes _____

Thyroid _____ Kidney _____

Arthritis _____ Tuberculosis _____

Stroke _____ Lung disease _____