Patient Case History Patient Name: ____

1) What is the main problem you want to work on today: ____

Date Started: ______/______/______ Are The Symptoms: Constant or Intermittent

How this began:____

Symptoms Feel : Sharp / Stabbing / Burning / Achy / Dull / Stiff / Sore / Shocking / Throbbing / Tight / Tingling / Numb

Any Treatments or Tests for this condition:
None - OR - Surgery – OR - ER/Ambulance: X-Rays/ MRI/ CT MD/ Ortho: X-Rays/ MRI/ CT
DC/ Acupuncture: X-Rays/ MRI/ CT PT: X-Rays/ MRI/ CT
OTC: ______________________________ Prescriptions/ Injection:______________________________

Is there any radiating (None - Pain – Numbness/ Tingling):
Head: Base of Skull / Forehead / Sides-Temples R / L / Both
Leg: Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both
Arm: Across Shoulder / Elbow / Hand-Fingers R / L/ Both

Circle ALL That Make Your Symptoms Worse: AM – PM – Activity – Inactivity – Bending – Computer – Drive/Travel – Exercise – Family Care – Heat – Ice – In/out of Chair – Lifting – Look Over Shoulder – Lying Down – OTC/Meds – Overuse – Personal Care – Reach Overhead – Recreation – Sitting – Sleep/Rest – Stairs – Standing – Stress – Stretching – Walk – Work – Yard Work – Nothing

2) Second problem after resolving your primary: ____

Date Started: ______/______/______ Are The Symptoms: Constant or Intermittent

How this began:____

Any Treatments or Tests for this condition:
None - OR - Surgery – OR - ER/Ambulance: X-Rays/ MRI/ CT MD/ Ortho: X-Rays/ MRI/ CT
DC/ Acupuncture: X-Rays/ MRI/ CT PT: X-Rays/ MRI/ CT
OTC: ______________________________ Prescriptions/ Injection:______________________________

3) Third problem after resolving your primary: ____

Date Started: ______/______/______ Are The Symptoms: Constant or Intermittent

How this began:____

Any Treatments or Tests for this condition:
None - OR - Surgery – OR - ER/Ambulance: X-Rays/ MRI/ CT MD/ Ortho: X-Rays/ MRI/ CT
DC/ Acupuncture: X-Rays/ MRI/ CT PT: X-Rays/ MRI/ CT
OTC: ______________________________ Prescriptions/ Injection:______________________________

Family Health History: ____

Personal Health History: ____

What illnesses do you take medication for now: ____

____, Medication Allergies: ____________________

Any drug or alcohol addictions/ recovery: No - Yes: Explain: ______________________________

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 to provide me with chiropractic & acupuncture care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient Signature:________________________, Date:______________, Doctor Signature________________

FOR OFFICE USE: Systolic: __________ Diastolic: _________ Pulse: _________ Height: _________ Weight: _________