IMBROGNO CHIROPRACTIC & HEALING ARTS CENTER
973-783-0444

CASE HISTORY

Name: _____ Age: _____ Date of birth: _____

Parent/Guardian Name (If Patient is a minor): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

E-mail _____ Occupation: _____

Emergency contact: _____
(Name, phone and relationship to you)

Who referred you to our office? _____ Have you had previous chiropractic care? _____

What is your reason for today's visit? _____

When did this condition begin? _____ Is it getting better, worse or the same? (please circle)

Do you experience: aching, numbness, pain, spasm, stabbing, stiffness, tingling, weakness, other? (circle ALL that apply)

% of time you experience symptoms: _____ Rate your pain: mild 1 2 3 4 moderate 5 6 7 8 severe 9 10 10+ (circle)

Is your condition worse: upon waking / morning / afternoon / evening / positional / during sleep / as the day progresses / all the time?

Do your symptoms radiate/refer to any other part of your body? _____

Does this condition interfere with your: daily routine / exercise / sleep / sports / computer / work / other?_____ (circle ALL that apply)

What helps your condition? _____

What aggravates your condition? _____

What are your goals for chiropractic care? (circle all that apply): pain/symptom relief corrective care supportive care

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

Have you received any other treatment for this condition? _____

Name of practitioner: _____

Are you still under care? _____ Approximate date of last treatment? _____

Have you had acupuncture, massage or any other bodywork? _____

Do you exercise regularly? _____ What form of exercise? _____

What do you do for stress reduction? _____

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

Please list ANY medically diagnosed conditions: _____

Date of last physical exam: _____ Name of primary care physician: _____

Do you have any history of cancer? _____

List ALL medications you take:_____

List ALL vitamins, herbs, or homeopathic remedies you take: _____

List hospitalizations and/or any surgical procedures: _____

List any falls, accidents, or injuries: _____

Have you ever had any of the following conditions (please circle ALL that apply): ADD / ADHD, Allergies, Anxiety, Arthritis, Asthma, Back Pain, Blood Pressure Disorders, Cancer, Concussion, Diabetes, Digestive Disorders, Dizziness, Ear Infections, Fractures, Headaches, Heart Problems, Herpes, Hepatitis (A, B, C), HIV, Learning Disabilities, Neck Pain, Nervousness, Sciatica, Scoliosis, Seizures, Sinus Problems, Vertigo, Weight issues, any other conditions: _____

For Women:

Age menstruation began: _____ Age menopause began: _____

Have you had any disorders of your reproductive system? _____

Ovarian / Uterine disorders: _____

Do you use an IUD? YES / NO Birth Control Pills? YES / NO Hormone Replacement Therapy? YES / NO

Do you have any disorders/difficulties with your menstrual cycles? _____

Number of births? _____ Vaginal delivery? _____C-Section? _____

Date of last GYN exam: _____ Name of gynocologist: _____

For Men:

Have you had any disorders of your reproductive system? _____

Prostate / Testicular disorders: _____

Have you ever had a PSA test? _____Were the results within normal limits? _____

Date of last prostate exam: _____ Name of urologist: _____

For Children/Adolescents:

Has your child been vaccinated? _____ When was the last vaccine? _____

Does your child frequently experience: attention issues, colds, sore throats, ear infections, digestive issues, sleep disturbances?

Has your child been on antibiotics in the last year? _____

Name of Pediatrician: _____

Is there ANYTHING else I should know about you or any aspect of your (or your child's) health? _____

_____

CONSENT FOR PROFESSIONAL SERVICES

I hereby authorize the doctor(s) to administer chiropractic examination, chiropractic care, treatment, order x-rays or imaging studies or any other services that (s)he deems necessary in my (or my child's) case.

Patient's signature _____ DATE _____

Parent or guardian signature _____ DATE _____