Patient Name: ______________________________ D.O.B.: ______________ Acct #: ________

Case History

Name: ____ Date: ________________

______ I have no pain or any other symptoms & I just want to have my spine examined. (Skip to * at bottom of page.)

[1]Below, **list the symptoms** you are having Begin with the symptom that hurts or troubles you the most.	[1]Is the pain **sharp**, **dull**, **throbbing, numbness**, **aching, shooting, tingling, cramping, burning, burning, stiffness,** etc.	[3]Put a pain scale on each (**1-10**). **1**=barely hurts **10**=worst pain ever	Is the pain **constant** or does it **come and go.**	Exactly **when** did the symptom begin?
Example: Migraine	Throbbing/Shooting	8	Comes and Goes	5/17/2017
1.				
2.				
3.				
4.				
5.				
6.				

[1]Do you suffer from any other condition or symptom? ______________________________

[1]I feel (circle one) **pain** / **numbness** in my: ____ Rt. Arm ____ Lt. Arm ____ Rt. Leg ____ Lt. Leg ____ Head

[1]How far down the arm or leg does the pain go? ______________________________

In general, since my condition began, it is getting: _____ Better _____ Worse _____ Same

[4]How often do you experience your problem per day? ____ 79-100% ____ 51-75% ____ 26-50% ____ 0-25%

[5]How much has pain interfered with daily activities? ___ extreme ___ a lot ___ moderately ___ a little ___ not at all

This was caused by: ____ Auto Accident ____ On the Job ____ Unknown ____ Other Date: ____________

[2]Describe further what caused your symptoms: ______________________________

What activity, position, or time of day seems to make your symptoms **worse**? ______________________________

What activity, position, or time of day seems to make your symptoms **better**? ______________________________

List all of the doctors you have seen for **this episode of this condition**:

	Doctor or Clinic Name	**Location**	**Date Last Seen**
1.			
2.			
3.			

Other than this episode, have you had a condition like this before: _____ No _____ Yes Results: ____________

If yes, list all the doctors you have seen for previous episodes:

	Doctor or Clinic Name	**Location**	**Date Last Seen**
1.			
2.			
3.			

*List all the doctors you have seen for **any condition within the last year**:

	Doctor or Clinic Name	**Location**	**Condition**	**Date Last Seen**
1.				
2.				
3.				

List all medications you are currently taking (including birth control pills and over-the-counter medications):

	Medication	**For What Condition?**
1.		
2.		

Patient Name: ______ D.O.B.: ______ Acct #: ______

[7]In general would you say your overall health right now is (circle one): Excellent Very Good Good Fair Poor

What is your occupation? _____ Professional/Executive _____ White Collar/Secretarial _____ Tradesperson _____ Laborer _____ Homemaker _____ FT Student _____ Retired _____ Other

What is your work status? _____ Full Time _____ Part Time _____ Self Employed _____ Unemployed _____ Other

Chiropractic or Acupuncture may sometimes help some of the following conditions, check those that apply to you:

Past	Present		Past	Present		Past	Present		Past	Present	
____	____	Migraines	____	____	PMS	____	____	Depression	____	____	High Blood Pressure
____	____	Allergies	____	____	Cramps	____	____	Heartburn	____	____	Sleep Disturbances
____	____	Colic	____	____	Anxiety	____	____	Indigestion	____	____	Irritable Bowel
____	____	Asthma	____	____	Belching	____	____	Ear Infections	____	____	Sinus Problems
____	____	Acid Reflux	____	____	Gas	____	____	Bed Wetting	____	____	Ear Ringing
____	____	Ulcers	____	____	Dizziness	____	____	Poor Vision	____	____	Tinnitus

Please check other conditions/symptoms which apply to you, please read carefully:

Past	Present		Past	Present		Past	Present	
____	____	Vertigo/Unsteadiness	____	____	Double Vision	____	____	Giddiness & Confusion
____	____	Diabetes	____	____	Frequent Urination	____	____	Loss of Bowel Control
____	____	Prostate Problems	____	____	Bloody Urination	____	____	Osteoporosis
____	____	Pacemaker	____	____	Painful Urination	____	____	Chest Pain
____	____	Stroke	____	____	Rheumatoid Arthritis	____	____	Cancer; where: _________
____	____	Abnormal Wt. Loss	____	____	Heart Disease	____	____	Fainting/Drop Attacks
____	____	Anemia	____	____	Night Pain	____	____	Permanent Disability Rating
____	____	Bleeding Disorders	____	____	Easily Bruised	List Your Rating: ______		

Do you have a family history of: _____ Diabetes _____ Heart Disease _____ Cancer _____ Kidney Disease

Do you take vitamins? _____ No _____ Yes Please List: ______

How much do you exercise? _____ None _____ Moderate _____ Daily Type: ______

Do you smoke? _____ No _____ Yes How Much: ______

Do you drink alcohol? _____ No _____ Yes How Much: ______

Do you drink coffee/tea/caffeinated drinks? _____ No _____ Yes How Much: ______

List any falls or injuries you had as a child? ______

List any hobbies that strain your spine (for example, golf, bowling, needlepoint, horseback riding, reading in bed, long period in front of computer): ______

List any accidents, falls, auto accidents, etc. that occurred throughout your life that could have contributed to your condition: ______

List all your lifetime surgeries you have had:

Type of Surgery	Date	Surgeon

Is there any chance that you could be pregnant? _____ No _____ Yes

Have you ever been to a chiropractor before? _____ No _____ Yes Doctor's Name: ______

Location: ______ Date: ______ Condition? ______

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