Chiropractic Case History

Name _____ Sex M F 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 reasons: _____

2. Chief Complaint: _____
Location of Complaint: _____
What was the initial cause of this complaint? _____
When did this complaint begin? _____
Are you presently under a doctor's care for this complaint? Y/N Doctors name:_____
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 other areas of your body? Y/N Where? _____
Do you have any numbness or tingling in your body? Where? _____
Grade Intensity/Severity (0 No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (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? _____
Does this complaint interfere with: work, home life, activities or sleep? Y/N _____

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**:** _____
Condition/s you are taking medications for: _____
F. Surgeries and dates: _____
G. Pregnancies, Date of Delivery & Outcomes _____
_____
H. Date of the beginning of your last menstrual period?_____ Any menstrual problems?_____

5. Family Health History:
Associated health problems of relatives: _____
Deaths in immediate family: _____
Cause of parents or siblings death & age at death _____

6. Social and Occupational History: _____
A. Level of Education: _____
B. Job description: _____
C. Recreational activities: _____
D. Do you take vitamins or supplements? Type and how often._____
E. Smoking and alcohol use. How often._____

On a scale of 1 – 10. How committed are you to resolving this complaint? ____
Are there any other health concerns you would like to address? _____

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/child with chiropractic care, in accordance with this state's statutes.

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____