Chiropractic Case History

Name _____ Sex I QG M F Date _____

Address_____City_____Sate____Zip_____

Home phone_____Cell_____Work Phone_____

E-mail_____Date of Birth_____Age_____

Government issue ID #:_____

Have you received chiropractic care? Yes No Referred by_____

Reason for seeking chiropractic care? _____

Chief Complaint (Main Complaint)/Specific Location:_____

When did the complaint begin/How?_____

Please circle the quality of complaint:

Dull Aching Sharp Shooting Burning Throbbing Deep Nagging Other_____

Does the complaint or pain travel or "shoot" to any other areas of your body? Where?_____

Do you have any tingling sensations or numbness in your body/ _____

Grade intensity/Severity: No complaint/Pain *0 1 2 3 4 5 6 7 8 9 10 Worst possible pain*

How frequent is pain present, and how long does it last?_____

Does anything make the complaint feel better? _____

Does anything make the complaint worse? _____

Do you have any other complaints that you haven't mentioned? _____

Have you sought previous interventions, treatments, medications, or surgery for this complaint? _____

Are you taking medication? Y N If yes, please list:

_____

_____

_____

Reason for taking medication and how long:

_____

_____

_____

List illnesses you have had: _____

Previous injury or trauma (broken bones, car accidents, severe sprains etc.) include approximate dates:_____

_____

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Surgeries:

Date: Type of surgery

_____ _____

_____ _____

Pregnancy:

Number of Pregnancies_____Outcomes and dates_____

How old were you when you began menstruating?_____What was the beginning of your last menstrual period?____

How would you describe your flow? (Mild Moderate Heavy) How long is your cycle?_____ is it regular? Y / N

Do you suffer from PMS? Y / N Explain _____

Is there any chance you might be pregnant Y / N Are you on oral contraception? Y / N which one_____

Have you experienced menopause? Y / N Are you experiencing perimenopause? Y / N

Is there a family history of	**Mother's side**	**Father's side**	**Patient**
Eye Disorders	Y / N	Y / N	Y / N
Lung Disorders	Y / N	Y / N	Y / N
Heart disease (stroke, heart attack, etc)	Y / N	Y / N	Y / N
Gastrointestinal disorders	Y / N	Y / N	Y / N
Endocrine disorders	Y / N	Y / N	Y / N
Arthritis	Y / N	Y / N	Y / N
Osteoporosis	Y / N	Y / N	Y / N
Diabetes	Y / N	Y / N	Y / N
Cancer	Y / N	Y / N	Y / N
Mental or emotional disorders	Y / N	Y / N	Y / N
Alcoholism	Y / N	Y / N	Y / N
other	Y / N	Y / N	Y / N

Job_____ Schedule_____Recreation_____

Diet (brief description): _____Waterintake_____

Caffeine Y / N How Much?_____ Alcohol Y / N How much? _____ Nicotine Y / N _____

I have read the above information and certify it to be true and correct tot he best of my knowledge.

_____ _____

(Patient or Guardian Signature) (Date)