Chiropractic Case History

Name ____Sex TG, I, QG, M, F Date _____________

Address__________________________________City___________________State____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)