

Chiropractic Case History

Name _____ Sex TG, I, QG, M, F Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ email _____

Date of Birth _____ Age _____

Government issue ID #: _____

Have you received chiropractic care before? 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(s) of the sensation/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? _____

Please grade intensity of pain: (No 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:

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)