

CASE NO. \_\_\_\_\_

## CONFIDENTIAL CASE HISTORY RECORD

Please fill out the following form in as much detail as possible.

Please Print

Date \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  M  F Referred by \_\_\_\_\_

Occupation/Job \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Marital Status  M  S  W  D Children \_\_\_\_\_ Name of Spouse \_\_\_\_\_

Is any other member of your family being treated in this office? \_\_\_\_\_

Have you ever had chiropractic care before? \_\_\_\_\_ Where? \_\_\_\_\_

For what problem? \_\_\_\_\_

Were the results satisfactory?  Yes  No

Major complaints and symptoms - please be as specific as you can. Ask the doctor or nurse for help if you need assistance in filling out this section.

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How do you believe your problem (pain) began? \_\_\_\_\_

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When did you first notice this problem/pain? \_\_\_\_\_

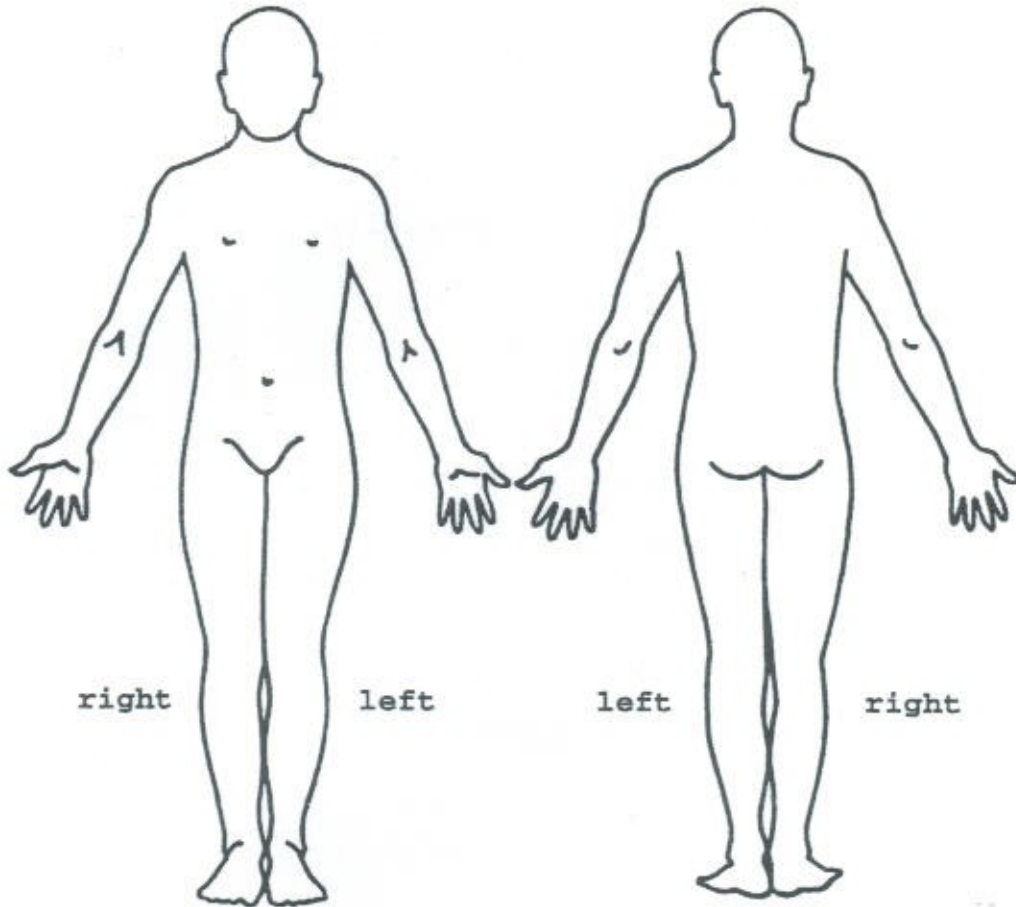
Have you lost any work? \_\_\_\_\_ Day and date you last worked \_\_\_\_\_

## PAIN CHART

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.  
Mark areas where the pain radiates - include all affected areas.

<u>Numbness</u>	<u>Pins &amp; Needles</u>	<u>Burning</u>	<u>Aching</u>	<u>Stabbing</u>
-----	00000	xxxxx	zzzzz	/////
-----	00000	xxxxx	zzzzz	/////
-----	00000	xxxxx	zzzzz	/////



**RATE YOUR PAIN: 0 = NO PAIN    10 = MOST INTENSE PAIN IMAGINABLE**

- |                 |   |   |   |   |   |   |   |   |   |   |    |
|-----------------|---|---|---|---|---|---|---|---|---|---|----|
| 1. At its worst | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. Right now    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. At its best  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Have you ever had this condition before or a similar condition? \_\_\_\_\_ When? \_\_\_\_\_

What positions or activities aggravate your condition? \_\_\_\_\_

What positions or activities relieve your condition? \_\_\_\_\_

Have you been treated by a Medical Physician for this ailment? \_\_\_\_\_ Where? \_\_\_\_\_

Describe the type of treatment \_\_\_\_\_

Diagnosis of previous physician \_\_\_\_\_

Length of time under care \_\_\_\_\_ Results \_\_\_\_\_

**Family History:** List any immediate family member who has had any of the following:  
Enter (M) - Mother; (F) - Father; (B) - Brother; (S) - Sister

- |   |  |
|---|--|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Arthritis       |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Mental Illness  |
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Colitis         |

Family physician's name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)? \_\_\_\_\_  
When? \_\_\_\_\_

Are you allergic to anything you are aware of? \_\_\_\_\_

Are you presently taking any medication (aspirin included)?  Yes  No

If Yes, name them \_\_\_\_\_

Have you ever broken any bones? (fractures)? \_\_\_\_\_ Any dislocations? \_\_\_\_\_

What operations have you had? \_\_\_\_\_ Year \_\_\_\_\_  
\_\_\_\_\_ Year \_\_\_\_\_  
\_\_\_\_\_ Year \_\_\_\_\_

Give dates you have had any of the following? (if exact date unknown, give approximate date)

Blood tests \_\_\_\_\_ MRI or CT Scan \_\_\_\_\_

X-ray examination \_\_\_\_\_ Bone Scan \_\_\_\_\_

At what hospital or office were these tests taken? \_\_\_\_\_

Name of doctor who ordered tests \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Do you have any reason to believe that you may be pregnant?  Yes  No

Do you have any health problems not listed above? \_\_\_\_\_

Have you ever had cancer?  Yes  No Where? \_\_\_\_\_

Does your pain wake you from a sound sleep?  Yes  No

Have you lost or gained weight in the past year?  Yes  No



Habits: (please check)

Cigarettes? Quantity \_\_\_\_\_ Activities/Hobbies \_\_\_\_\_

Coffee? Quantity \_\_\_\_\_

Alcohol? Quantity \_\_\_\_\_ Please list any vitamins you take \_\_\_\_\_

Tea? Quantity \_\_\_\_\_

Use this space for any additional information you may wish to discuss \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you. Please check the now or past column if it applies to you.

	<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>
Headaches	___	___	Loss of Memory	___	___	High Blood Pressure	___	___
Neck Pain	___	___	Chest Pains	___	___	Cold Hands	___	___
Mid Back Pain	___	___	Shortness of Breath	___	___	Cold Feet	___	___
Low Back Pain	___	___	Allergies	___	___	Leg Cramps	___	___
Arm/Hand Pain	___	___	Hay Fever	___	___	Fever	___	___
Arm/Hand Numbness	___	___	Frequent Colds	___	___	Night Sweats	___	___
Arm/Hand Weakness	___	___	Sinus Problems	___	___	Stomach Upset	___	___
Leg/Foot Pain	___	___	Arthritis	___	___	Indigestion	___	___
Leg/Foot Numbness	___	___	Swollen Joints	___	___	Belching	___	___
Leg/Foot Weakness	___	___	Muscle Spasms	___	___	Vomiting	___	___
Fainting	___	___	Nervousness	___	___	Diarrhea	___	___
Dizziness	___	___	Tension	___	___	Constipation	___	___
Loss of Balance	___	___	Irritability	___	___	Colitis	___	___
Ringing in Ears	___	___	Fatigue	___	___	Hemorrhoids	___	___
Blurred Vision	___	___	Depression	___	___	Difficulty Urinating	___	___
Loss of Smell	___	___	Sleeping Problems	___	___	Gall Bladder	___	___
Loss of Taste	___	___	Menstrual Difficulties	___	___	Diabetes	___	___

I understand that a complete and accurate case history is necessary in order for the Doctor to provide the most appropriate treatment. I hereby acknowledge that the above information is accurate and complete to the best of my knowledge and recollection, and that I haven't knowingly omitted any information in regard to my medical history.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE PRINT NAME \_\_\_\_\_