



# Confidential Patient Case History

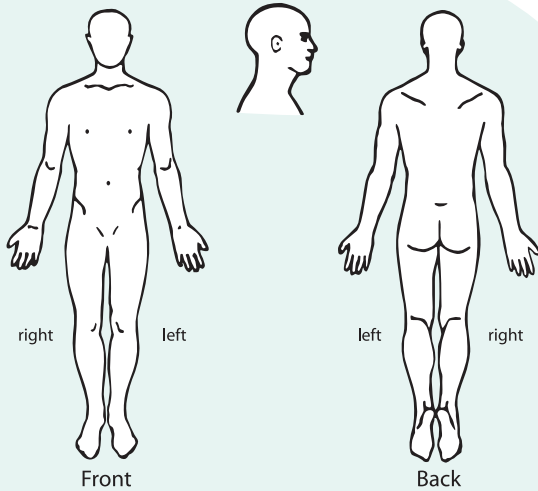
**1.** Today's Date: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Referred by: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Age: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_  Male  Female  
 Employer: \_\_\_\_\_  
 Status:  Single  Married  Divorced  Separated  Widowed  Domestic Partner  
 Spouse's/Partner's Name: \_\_\_\_\_  
 Do you have children?  Yes  No Ages: \_\_\_\_\_

**2.** Have you seen a chiropractor before?  Yes  No  
 Dr.: \_\_\_\_\_ Your last visit? \_\_\_\_\_  
 Why did you see this chiropractor? \_\_\_\_\_  
 \_\_\_\_\_  
 Were you helped?  Yes  No  
 What spinal maintenance programs were you given to follow to maximize the future stability of your spine? \_\_\_\_\_  
 \_\_\_\_\_  
 Did you follow it?  Yes  No If not, why? \_\_\_\_\_  
 \_\_\_\_\_  
 Why are you changing chiropractors? \_\_\_\_\_  
 \_\_\_\_\_

**3.** If you have **no symptoms** or complaints, and are here for wellness services, please check here  **"Wish to have Chiropractic Wellness Services"** and skip to section 5. Others need to briefly describe the chief area of complaint. \_\_\_\_\_  
 \_\_\_\_\_  
 When did it begin? \_\_\_\_\_  
 Is it getting worse?  Yes  No  Constant  Comes and Goes  
 Yes, it interferes with:  Work  Sleep  Walking  Sitting  Standing  Leisure  
 Hobbies \_\_\_\_\_  
 Have you had the same or similar problem in the past?  Yes  No  
 Have you consulted with any other health practitioner for this problem?  Yes  No  
 Dr. \_\_\_\_\_

4.

**PLEASE MARK ALL AFFECTED AREAS WITH THE APPROPRIATE SYMBOLS**



Stabbing/Sharp Pain: / / / / /  
 Numbness: - - - - -  
 Pins and Needles: o o o o o  
 Burning: x x x x x  
 Aching Pain: c c c c c  
 Stiffness: # # # # #

Below is a pain scale to rate the severity of your problems. Please note the area of pain and circle the appropriate number next to it.

**Area of Complaint:**

	No Pain = 0					Excruciating Pain = 10					
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

5.

**PLEASE MARK PAST (O) OR PRESENT (X) CONDITIONS:**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>___ <b>Fractured Bones</b></li> <li>___ Auto Accidents</li> <li>   (a)___ 0-1 year ago</li> <li>   (b)___ 1-5 years ago</li> <li>   (c)___ More than 5 years</li> <li>___ Other Accidents/Falls</li> <li>___ Knocked Unconscious</li> <li>___ Back Curvature</li> <li>___ Mental or Emotional Disorders</li> <li>___ Arthritis</li> <li>___ Diabetes</li> <li>___ Swollen or painful joints</li> <li>___ Convulsions/Epilepsy</li> <li>___ Skin problems</li> <li>___ Bruise easily</li> <li>___ Cancer</li> <li>___ Frequent Colds/Flu</li> <li>___ <b>Nervous</b></li> <li>___ Tension</li> <li>___ Depression</li> <li>___ Irritable</li> <li>___ Anemia</li> <li>___ Excess Sweating</li> <li>___ Tremors</li> <li>___ Light Bothers Eyes</li> <li>___ Allergy</li> <li>___ Sinus Problems</li> <li>___ Light Headed Upon Rising</li> <li>___ Under Stress</li> <li>___ Craves Sweets or Salts</li> <li>___ Eating Disorders</li> </ul> | <ul style="list-style-type: none"> <li>___ <b>Trouble Sleeping</b></li> <li>___ Trouble Concentrating</li> <li>___ Loss of Memory</li> <li>___ Learning Disability</li> <li>___ Stutter</li> <li>___ Dyslexia</li> <li>___ Mood Changes</li> <li>___ Lose Temper Easily</li> <li>___ Ear Infections</li> <li>___ <b>Headache</b></li> <li>___ Neck pain or stiffness <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Numbness, tingling or pain in arms, hands, fingers <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Jaw pain or click/(TMJ) <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Head seems too heavy</li> <li>___ Head and shoulders feel tired</li> <li>___ Difficulty in excessive (please circle) standing sitting walking riding bending lifting twisting household duties</li> <li>___ Shoulder Pain <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Dizziness</li> <li>___ Ringing in ears <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Hearing Loss <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Fainting</li> <li>___ Loss of balance</li> <li>___ Blurred or double vision <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Upper back pain or stiff <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Mid back pain or stiff <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Lower back pain or stiff <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Numbness, tingling or pain in buttocks, thighs, legs, feet and/or toes <input type="checkbox"/>Right <input type="checkbox"/>Left</li> </ul> | <ul style="list-style-type: none"> <li>___ Hip Pain <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ Foot Trouble <input type="checkbox"/>Right <input type="checkbox"/>Left</li> <li>___ <b>Chest Pain</b></li> <li>___ Asthma</li> <li>___ Lung Problems</li> <li>___ Difficulty Breathing</li> <li>___ Wheezing</li> <li>___ Heart Problems</li> <li>___ Stroke</li> <li>___ High or low blood pressure</li> <li>___ Varicose Veins</li> <li>___ Liver trouble</li> <li>___ Gall Bladder Trouble</li> <li>___ <b>Digestive problems</b></li> <li>___ Excessive gas</li> <li>___ Belching/bloating after meals</li> <li>___ Heartburn</li> <li>___ Ulcers</li> <li>___ Diarrhea/Constipation</li> <li>___ Colon Trouble</li> <li>___ Hemorrhoids</li> <li>___ Prostate Problems</li> <li>___ Impotence</li> <li>___ <b>Kidney Trouble/Stones</b></li> <li>___ Frequent Urination</li> <li>___ Discharge</li> <li>___ Menstrual Problems</li> <li>___ Menopausal Problems</li> <li>___ Breast lumps, soreness, discharge</li> <li>Pregnant <input type="checkbox"/>Yes <input type="checkbox"/>No</li> <li>Date of last period _____</li> </ul> |
|--|---|---|

*The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.*

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_