

Chiropractic Case History

Name _____ Date _____

Sex: M F Married Single Divorced

Address _____ City _____ State _____ Zip _____

Phone _____ Work _____ Cell _____ Date of Birth ____/____/____

Referred By _____ Social Security # _____

Occupation _____ Employer _____

Email _____ I would like to receive email notifications from this office.

Have you ever received Chiropractic Care? Yes No If yes, when and by whom? _____

1. Primary reasons for seeking chiropractic care:

Primary Reason _____

Secondary Reason _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint:

Location of Complaint: _____

Complaint began when and how? _____

Please select the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging Other: _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Grade Intensity/Severity: 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10
(no complaint/pain) (worst possible complaint/pain imaginable)

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

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint?

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

Allergies: _____

D. Medications:

Medication:

Reason for taking:

E. Surgeries:

Date:

Type of Surgery:

F. Females – Pregnancies & Outcomes:

Pregnancies/Date of Delivery:

Outcome:

What was the date of beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents' or siblings' death

Age at death

6. Social and Occupational History:

A. Level of Education:

High school

Some college

College graduate

Post graduate studies

B. Job Description: _____

C. Work Schedule: _____

D. Recreational Activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco, and drug use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____