

Chiropractic Case History

Name _____ Sex M F Married ___ Single ___ Divorced ___ Date _____

Address _____ City _____ State _____ Zip _____

Home _____ 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 & by who? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Factors contributing to the primary and secondary reasons: _____

Location of Complaint: _____

Complaint began when and how? _____

Please circle 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? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

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

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

2. Previous treatments, medications, surgery, or care you've sought for your complaint: _____

3. Past Health History:

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

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Reason for taking

_____	_____
_____	_____
_____	_____

E. Surgeries:

Date & Type:

_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery or other Outcome

_____	_____
_____	_____

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

4. Family Health History:

Associated health problems of relatives: _____

Cause and age of parents or siblings death

5. 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 _____

Doctor's Signature _____ Date _____