

Case History



Name _____ Date _____

Street _____ City _____ State _____ Zip _____

Mailing Address (if different than street address): _____

H. Phone _____ W. Phone _____ Cell Phone: _____

E-mail address: _____ Birth Date _____ Age _____ Sex: M F

If female, is there a possibility that you might be pregnant? YES NO Marital Status: M S W D No. of children _____

Occupation _____ Employer _____

Spouse's Name _____ Spouse's Employer/Occupation _____

Who should we call in an emergency? Name _____ Phone _____

List any times you were hospitalized _____

List any surgeries (include date) _____

Previous Injuries: _____

Yes	No	Health Habits	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you maintain a good posture?	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink 2 or more alcoholic beverages each day?
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take nutritional supplements?
<input type="checkbox"/>	<input type="checkbox"/>	Do you eat 5 or more servings of fruits or vegetables each day?	<input type="checkbox"/>	<input type="checkbox"/>	Do you consider yourself to be healthy?
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently feel emotionally stressed?

In the following list, please check all of the conditions that you have experienced in the past year.

HEAD	<input type="checkbox"/> Headache	<input type="checkbox"/> Numbness or tingling in hands	<input type="checkbox"/> Pain in hip joint	<input type="checkbox"/> Difficulty starting urination
<input type="checkbox"/> Migraine	<input type="checkbox"/> Head feels heavy	<input type="checkbox"/> Loss of strength in arms	<input type="checkbox"/> Pain down upper leg	<input type="checkbox"/> Night urination
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of strength in hands	<input type="checkbox"/> Pain down below knee	GENERAL
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Ringing in ears	BACK	<input type="checkbox"/> Pain in both legs	<input type="checkbox"/> Nervousness
NECK	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Irritable
<input type="checkbox"/> Grinding sounds in neck	SHOULDERS	<input type="checkbox"/> Mid-back pain	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Pain in shoulders	<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> Rib pain	<input type="checkbox"/> Numbness or tingling in legs	<input type="checkbox"/> Depression
ARMS & HANDS	<input type="checkbox"/> Pain in arm	<input type="checkbox"/> Pain when breathing	<input type="checkbox"/> Numbness or tingling in toes	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Pain in hands	<input type="checkbox"/> Numbness or tingling in arm	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/> Numbness or tingling in arm	ABDOMEN - DIGESTION	ABDOMEN - DIGESTION	WOMEN ONLY	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Cancer
	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Cramping	<input type="checkbox"/> Breathing problems
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Constipation	<input type="checkbox"/> Irregularity	<input type="checkbox"/> Asthma
	<input type="checkbox"/> Heart burn	<input type="checkbox"/> Heart burn	<input type="checkbox"/> Menopause	<input type="checkbox"/> Allergies
	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Pre-menstrual Syndrome	<input type="checkbox"/> Sinus trouble
	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nausea	MEN ONLY	<input type="checkbox"/> Epilepsy
	HIPS, LEGS & FEET	<input type="checkbox"/> Pain in buttocks	<input type="checkbox"/> Urinary frequency	<input type="checkbox"/> High blood pressure
				<input type="checkbox"/> Difficulty losing weight

Describe Your Primary Complaints Below

Describe Complaint #1: _____

What does it feel like: Sharp Dull Burning Tingling Stabbing Numb Aching Weak

When did it start? _____ What caused it or what were you doing? _____

How often do you feel it? Is it Constant , **OR** _____ times per Day, Week, Month, or Year

What makes it worse? _____ What makes it better? _____

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint and a "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10
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Is it worse in the: Morning Mid-day Evening Doesn't Matter. Did it occur Suddenly or Gradually?

Does anyone else in the family have this problem? _____

Describe Complaint # 2: _____

What does it feel like: Sharp Dull Burning Tingling Stabbing Numb Aching Weak

When did it start? _____ What caused it or what were you doing? _____

How often do you feel it? Is it Constant , **OR** _____ times per Day, Week, Month, or Year

What makes it worse? _____ What makes it better? _____

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint and a "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Is it worse in the: Morning Mid-day Evening Doesn't Matter Did it occur Suddenly or Gradually?

Does anyone else in the family have this problem? _____

Describe Complaint # 3: _____

What does it feel like: Sharp Dull Burning Tingling Stabbing Numb Aching Weak

When did it start? _____ What caused it or what were you doing? _____

How often do you feel it? Is it Constant , **OR** _____ times per Day, Week, Month, or Year

What makes it worse? _____ What makes it better? _____

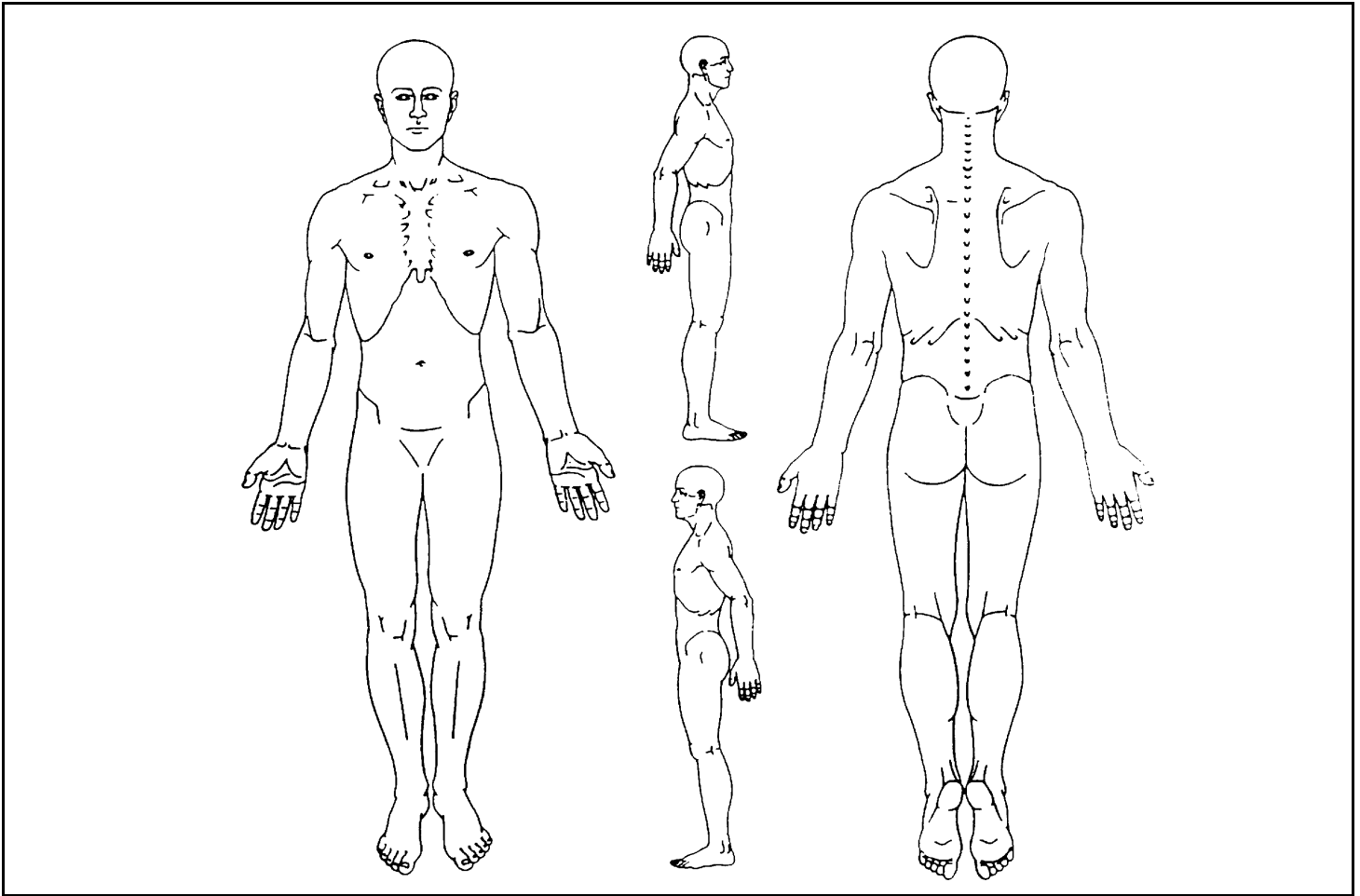
Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint and a "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Is it worse in the: Morning Mid-day Evening Doesn't Matter Did it occur Suddenly or Gradually?

Does anyone else in the family have this problem? _____

In the box below, please mark the areas of pain or other symptoms.



Check the following activities that you have had trouble performing since your complaints started and rate the difficulty.

	No Problem	Some Difficulty	Very Difficult	Can't Do		No Problem	Some Difficulty	Very Difficult	Can't Do
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gardening/Yard Work ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweeping/Mopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fixing Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leisure Activities				

Other Affected Activities

_____ Some Difficulty Very Difficult Can't Do

_____ Some Difficulty Very Difficult Can't Do

Have you ever received Chiropractic care? Y / N If yes where? _____

List other doctors consulted for present complaints:

Name _____ When _____ Diagnosis _____ Treatment _____

Name _____ When _____ Diagnosis _____ Treatment _____

Drugs you now take: _____

Informed Consent: The role of a chiropractor is to help restore function to the spine through chiropractic adjustments. As this is done, most patients experience improvement in spine related conditions. The speed or extent of improvement is to a large degree dependent upon the inherent recuperative abilities of each patient. Some experience very rapid results, some slower results. A small percentage receive no outward benefit. Chiropractic does not treat pain, although most patients do experience reduced pain. Occasionally some patients experience a short-term increase in pain. We also do not diagnose and treat diseases other than those directly related to or caused by spinal misalignments. If you have other conditions that you wish evaluated, please consult with your medical doctor. As with any health care procedure, chiropractic adjustments have some risk. Increased risk often results from some underlying weakness or condition possessed by the patient that is not readily apparent through routine examination. Serious complications to chiropractic adjustments are considered by most authorities to be very rare, occurring once per one million adjustments. By individuals not properly trained, the risk can be much greater. When evaluating risks and benefits of health care procedures, you must consider the risk of not receiving care. Patients who choose medical care rather than chiropractic choose to accept the even greater risks associated with many medications and surgical procedures. Most chiropractic experts and patients agree that the benefits of chiropractic far outweigh the risks, however there are some risks. During the course of your care, you will be required to position yourself on the treatment tables and turn over on the tables. Although very rare, there have been occasions where patients have fallen off of a treatment table. By signing below you acknowledge that you understand the above risks and agree to continue with your care. You also acknowledge that you are capable of positioning yourself on the tables without assistance.

Patient's signature

Date