

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex: M F  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Please circle one: Married Single Divorced  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #'s: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Email: \_\_\_\_\_

\*\* Your Email address will only be used for internal purposes. We will not share your information with anyone without your permission.

Have you ever received Chiropractic Care?  Yes  No If yes, when & by whom? \_\_\_\_\_

Will you be using insurance for your visit with us? (Please Circle) Yes No

**\*\*\*Please set this form to the side along with your driver's license and insurance card (if applicable). We will come to get it from you in a moment.\*\*\***

**Chiropractic Case History**

Name \_\_\_\_\_

**1. Primary reasons for seeking chiropractic care:**

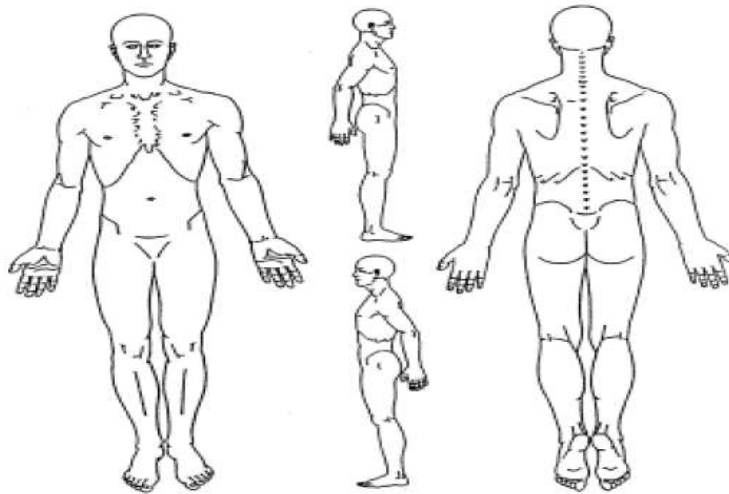
Primary reason: \_\_\_\_\_

Secondary reason: \_\_\_\_\_

Other factors contributing to the primary and secondary reasons: \_\_\_\_\_

**2. Chief Complaint:** \_\_\_\_\_

Location of Complaint: \_\_\_\_\_



Complaint Began when and how? \_\_\_\_\_

Please 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? \_\_\_\_\_

Name \_\_\_\_\_

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

\_\_\_\_\_

**4. Past Health History:**

A. Previous serious illnesses you've had in your life: \_\_\_\_\_

\_\_\_\_\_

B. Previous injury or trauma: \_\_\_\_\_

\_\_\_\_\_

Have you ever broken any bones? Which? \_\_\_\_\_

C. Allergies \_\_\_\_\_

**D. Medications:**

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

**E. Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

Do you have any reason to believe you may be pregnant? \_\_\_\_\_

What was the date of the 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
_____	_____
_____	_____
_____	_____

Name \_\_\_\_\_

**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):** \_\_\_\_\_

Please check each of the conditions you are currently experiencing:

**MUSCULO SKELETAL SYSTEM**

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

**GENITO-URINARY SYSTEM**

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

**FEMALE**

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

**EYE, EAR, NOSE AND THROAT**

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

**GASTRO-INTESTINAL SYSTEM**

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

**CARDIO-VASCULAR RESPIRATORY**

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

**NERVOUS SYSTEM**

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

**HABITS**

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- \_\_\_\_\_

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 \_\_\_\_\_