Case History

Name _____ Date _____

Ethnicity:_____ Race:_____ Language: _____

Address _____ City_____ State_____ Zip _____

Cell Phone (_____) _____ Cell Carrier _____ Date of Birth _____ (Age _____)

Referred by _____ Work Phone (____) _____

Occupation _____ Employer _____

Marital Status S M D W Number of Children and Ages _____

Have you ever received Chiropractic Care? Yes ❑ No ❑

Social Security # _____ Email Address _____

Emergency Contact/Phone _____

As you increased your layers of damage you probably began to experience symptoms and random bouts of sickness.
Leave blank if does NOT apply..

Yes	No	(Age 5 - Present)	Patient Comment if answer is Yes	Notes
❑	❑	Were you taught proper body movements and care?		
❑	❑	Did/do you smoke? If so, how much?		
❑	❑	Did/do you drink any alcohol?		
❑	❑	Weight gain or loss?		
❑	❑	Have you been in accidents?		
❑	❑	Allergies Food/Drug/Environmental?		
❑	❑	Teeth problems?		
❑	❑	Eye problems?		
❑	❑	Hearing problems?		
❑	❑	Exercise regularly?		
❑	❑	Loss of sleep?		
❑	❑	Did/do you have occupational stress?		
❑	❑	Physical stress?		
❑	❑	Mental stress?		
❑	❑	Hobbies/Sports injuries?		
❑	❑	Other traumas or problems		
❑	❑	Sleep posture ❑ Side ❑ Stomach ❑ Back		

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present Complaint (Be Specific)

Major complaint _____

_____

_____

Pain or Problem started on _____

Pains are: ❑ Sharp ❑ Dull ❑ Constant ❑ Intermittent

On a scale of 1 to 10, how is your pain level _____

What activities aggravate your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms: O - Occasional, F - Frequent, C - Constant. **Leave blank if does not apply.**

O	F	C		O	F	C		O	F	C		O	F	C	
☐	☐	☐	Headaches	☐	☐	☐	Pins & Needles in Legs	☐	☐	☐	Fainting	☐	☐	☐	Acid Reflux
☐	☐	☐	Neck Pain	☐	☐	☐	Pins & Needles in Arms	☐	☐	☐	Loss of Smell	☐	☐	☐	Fever
☐	☐	☐	Sleeping Problems	☐	☐	☐	Numbness in Fingers	☐	☐	☐	Loss of Taste	☐	☐	☐	Buzzing in Ears
☐	☐	☐	Mid Back Pain	☐	☐	☐	Numbness in Toes	☐	☐	☐	Diarrhea	☐	☐	☐	Arm Pain
☐	☐	☐	Nervousness	☐	☐	☐	Shortness of Breath	☐	☐	☐	Feet Cold	☐	☐	☐	Bladder Control
☐	☐	☐	Tension	☐	☐	☐	Fatigue	☐	☐	☐	Hands Cold	☐	☐	☐	Bowel Control
☐	☐	☐	Chest Pain	☐	☐	☐	Depression	☐	☐	☐	Stomach Upset	☐	☐	☐	Elbow Pain
☐	☐	☐	Dizziness	☐	☐	☐	Lights Bother Eyes	☐	☐	☐	Constipation	☐	☐	☐	Sciatica
☐	☐	☐	Face Flushed	☐	☐	☐	Loss of Memory	☐	☐	☐	Cold Sweats	☐	☐	☐	Skin Problems
☐	☐	☐	Neck Stiff	☐	☐	☐	Ears Ring	☐	☐	☐	Loss of Balance	☐	☐	☐	
☐	☐	☐	Low Back Pain	☐	☐	☐	Caffiene Use								

List Vitamins and Herbal Support _____

_____

Have you been under medical care? _____

What medications are you taking? _____

_____

_____

_____

List all surgeries and date of surgery: _____

_____

_____

What side effects have you experienced from the drugs and surgery? _____

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❑	❑	❑	❑	❑
Mother's Side	❑	❑	❑	❑	❑

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I agree to pay a percentage of services or co-pay as they are rendered in accordance with my insurance policy. However, I understand I am ultimately responsible for the full amount of payment for services rendered.

Signature of patient or guardian _____

Consent to Treat a Minor _____

Signature of person responsible for payment _____

Date _____