

CONFIDENTIAL CASE HISTORY FILE

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Date: _____

Full Legal Name: _____ Name you prefer: _____

Address: _____ City/State/Zip _____

Phone: (home) (____) _____ (work) (____) _____ Soc Sec# _____ - _____ - _____

Birth date: ____/____/____ Age: _____ Sex: _____ Marital Status: S M W D Sep

Spouse's Name: _____ # Children _____ Years of Education _____

Emergency Contact: _____ Phone: (____) _____

Your Employer: _____ Phone: (____) _____

Employer's Address: _____ City/State/Zip _____

Job title: _____ Supervisor Name: _____

e-mail address: _____ Referred by: _____

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.): _____

List all current over-the-counter and prescription medications used (include reason used): _____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.) _____

Have you been under a physician's care in the past year? no yes (reason) _____

When was your last physical examination? _____ Dr: _____

Have you ever been under chiropractic care? no yes (describe) _____

If female, is there a possibility that you are pregnant? no yes

Do you smoke/use tobacco? no yes Exercise habits? never occasional frequent

Check any of the following symptoms you have noticed: (= Previously, = Now)

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Sensitive to light or sound |
| <input type="checkbox"/> Dizziness or light-headed | <input type="checkbox"/> Leg/foot numbness/tingling | <input type="checkbox"/> Visual or hearing disturbance |
| <input type="checkbox"/> Jaw pain, clicking, or locking | <input type="checkbox"/> Leg/foot fatigue/weakness | <input type="checkbox"/> Memory loss/problems |
| <input type="checkbox"/> Pain or difficulty swallowing | <input type="checkbox"/> Leg pain with walking | <input type="checkbox"/> Irritability or depression |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Fatigue or loss of energy |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Fainting or convulsions |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Diarrhea or constipation | <input type="checkbox"/> Trouble with balance or coordination |
| <input type="checkbox"/> Chest pain or cough | <input type="checkbox"/> Blood in urine or stool | <input type="checkbox"/> Sleep disturbances/problems |
| <input type="checkbox"/> Pain/trouble breathing | <input type="checkbox"/> Difficulty or pain w/ urination | <input type="checkbox"/> Rashes (face, body, limbs) |
| <input type="checkbox"/> Arm/hand numbness/tingling | <input type="checkbox"/> Difficulty with sexual function | <input type="checkbox"/> Joint pain or swelling |
| <input type="checkbox"/> Arm/hand fatigue/weakness | <input type="checkbox"/> Abnormal menstrual periods | <input type="checkbox"/> Pain with exertion (activity, climbing stairs, etc.) |

HAVE YOU HAD ANY OF THE FOLLOWING:	NOW:	<input type="checkbox"/> Recent bacterial infection (30 days)	EVER:
	<input type="checkbox"/> Pain worse at night	<input type="checkbox"/> Loss of bowel or bladder control	<input type="checkbox"/> History of cancer
	<input type="checkbox"/> Constant pain	<input type="checkbox"/> Urinary discharge	<input type="checkbox"/> History of IV drug use
	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Recent surgery (30 days)	<input type="checkbox"/> History of blood transfusion

Information about your current condition/complaints

What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: Constant Intermittent

Is your condition getting worse? _____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. _____

2. _____

3. _____

Have you had: Xray MRI or CAT Scan EMG Bone Scan Blood Work

Who is your family medical doctor: _____

List all home remedies tried for this problem: _____

Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) work _____ sleep _____ normal daily routine _____

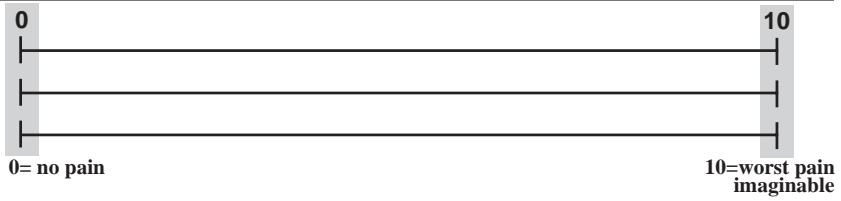
Have you had symptoms like this before? no yes (describe) _____

Regarding your main complaint:

1. RIGHT NOW:

2. AVERAGE:

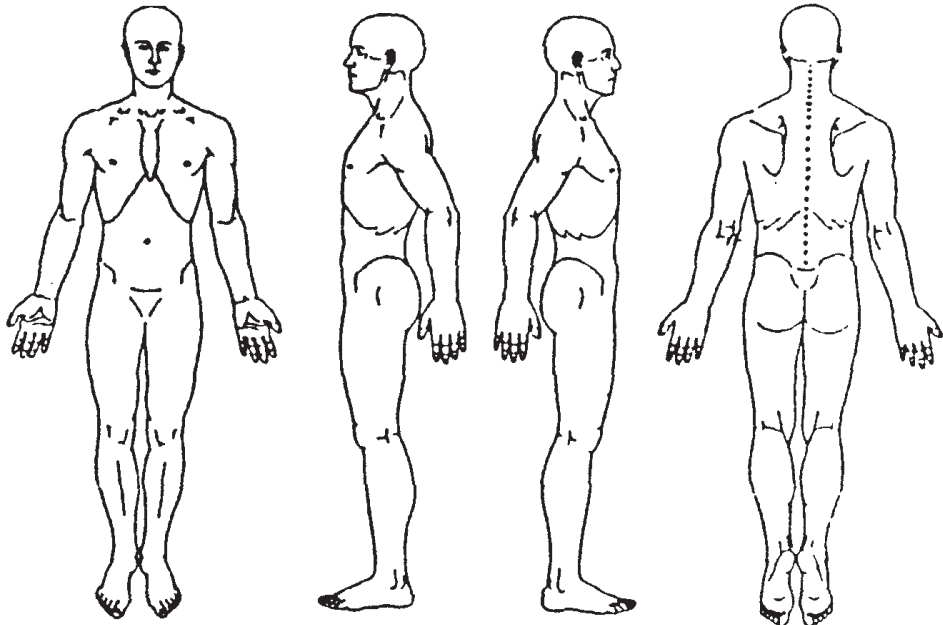
3. AT WORST:



How bad is your pain?
(make a slash on all 3 scales)

Draw the area of your symptoms using these symbols:
(mark on the figures)

- XXX = ache
- * = sharp/stab
- ooo = numb/tingle
- = shooting
- //// = stiff/tight



NOTICE TO NEW PATIENTS: Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.

Patient Signature: _____ Date _____