Seebacher Family Chiropractic Center- 1385 Old Freeport Rd., Pittsburgh, PA 15238 412-449-1000

Date_____

Chiropractic Case History Form

Name_____ **Sex** M F Social Security #_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home#(_____)_____Work#_____ Cell#_____

Date of Birth_____ **Age**_____ Marital Status: ___ Married ___ Single ___Divorced ___Widowed

Email address_____ Would you like to receive our e-mail newsletter? ☐ Yes ☐ No

Referred by_____ Employer/Occupation_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____By whom?_____

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? _____

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

_____

4. Past Health History:

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

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Medications:

Medication (s) Reason for taking

_____ _____

_____ _____

_____ _____

D. Allergies

_____

_____

_____

E. Surgeries:

Date Type of Surgery

_____ _____

_____ _____

F. Females/ Pregnancies and outcomes:

Please check one: ☐ Pregnant ☐ Not Pregnant

Pregnancies/Date of Delivery Outcome

_____ _____

_____ _____

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

G.Family Health History:

Associated health problems of relatives:

_____

_____

H. Deaths in immediate family:

Cause of parents or siblings death Age at death

_____ _____

_____ _____

_____ _____

I. Social and Occupational History:

1) Level of Education:

O high school O some college O college graduate O post graduate studies

2) **Job description:** _____

3) **Work schedule:** _____

4) **Recreational activities:** _____

5) **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**_____

_____

J. Contact Information (In-case of an emergency, who can we contact) :

Name_____**Address, City, State, Zip**_____

Phone# _____ **Relationship to Patient** _____

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.

Parent or Guardian Signature _____ **Date**_____

Patient Signature _____ **Date** _____