CASE HISTORY

Name (print): _____ **Date:** _____
Address: _____ **Home Phone:** _____
_____ **Work Phone:** _____
Date of Birth: _____ **Occupation:** _____
How did you find out about us? _____

☐ **I have no symptoms and I just want to have my spine examined (skip to next page)**

Below, list the symptoms you are having. Begin with the symptom that hurts / troubles you the most- then go down the list until you have listed all of your symptoms. *	Put a number on each symptom (1-10) 1= "barely hurts" 10=the worst pain you've ever had	When did this symptom begin? (Please give exact dates when possible)
1. _____	_____	Date Began: _____ ☐Constant ☐Comes and Goes
2. _____	_____	Date Began: _____ ☐Constant ☐Comes and Goes
3. _____	_____	Date Began: _____ ☐Constant ☐Comes and Goes
4. _____	_____	Date Began: _____ ☐Constant ☐Comes and Goes
5. _____	_____	Date Began: _____ ☐Constant ☐Comes and Goes

Other Symptoms/Condition: _____

- I feel (CIRCLE) Pain / Numbness in my: ☐Rt. Arm ☐Lt. Arm ☐Rt. Leg ☐Lt. Leg ☐Headaches ☐N/A
- How far down the arm or leg does the pain go? _____
- In general, is your condition getting: ☐ Better ☐ Worse ☐ Same
- What do you think caused this condition? ☐Automobile accident ☐Unknown Date of Incident_____
  ☐ Other: _____
- What activity, position, or time of day seems to make your symptoms worse?
  _____
- What activity, position, or time of day seems to make your symptoms better?
  _____

List all the doctors you have seen for this condition, or for *any* condition if it was *within the last year*:

	Doctor/Office *	**Location**	**Date Last Seen**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

- Other than this episode- Have you had a condition like this before? ☐ Yes When: _____ ☐No
  What treatment did you have and by who? _____
  What were the results? ☐ Good ☐Temporary ☐ Didn't help ☐ Other: _____

***ASK RECEPTIONIST FOR SEPARATE SHEET IF NEEDED** **(OVER)**

- Are you currently taking medications: ☐ Yes ☐ No

List Medication*: **For What Condition?**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

- Do you take Vitamins? ☐ **Yes** List: _____ ☐ No
- **CHIROPRACTIC MAY SOMETIMES HELP SOME OF THE FOLLOWING CONDITIONS, OR THEY CAN AFFECT YOUR SPINAL CONDITION AND HEALING TIME. CHECK THOSE THAT APPLY TO YOU.**

Past	Present		Past	Present	
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Diabetes	☐	☐	Painful Urination
☐	☐	Constipation	☐	☐	Stroke
☐	☐	Diarrhoea	☐	☐	Arthritis
☐	☐	Frequent Urination	☐	☐	Cancer Where: _____
☐	☐	PMS	☐	☐	Abnormal Weight Loss
☐	☐	Loss of Bladder/Bowel Control	☐	☐	Heart Attack
☐	☐	Headache	☐	☐	Epilepsy
☐	☐	Heartburn/Indigestion	☐	☐	Seizures
☐	☐	Sinus Problems	☐	☐	Dizziness
☐	☐	Prostate Problems	☐	☐	Fainting
☐	☐	Colitis	☐	☐	AIDS/HIV
☐	☐	Menstrual Problems	☐	☐	Night Sweats/Fevers
☐	☐	Asthma	☐	☐	Other: _____

- Do you smoke? ☐ Yes: (How Much) _____ ☐ No
- Do you drink alcohol? ☐ Yes: (How Much) _____ ☐ No
- Do you drink coffee/tea/caffeinated drinks? ☐ Yes: (How Much) _____ ☐ No
- Do you take birth control pills? ☐ Yes ☐ No
- Do you sleep on your ☐ Side ☐ Back ☐ Front ☐ All over
- As a child, did you have any falls or injuries that could have affected your current spinal condition? ☐ No ☐ **Yes** Details: _____
- Do you have any hobbies that strain your spine? ☐Bowling ☐Horses ☐Needlepoint ☐Golf ☐ Reading in Bed ☐ Other: _____
- Have you *ever* had any accidents, falls, auto accidents, etc. that could have contributed to your current condition?☐ **Yes** Details: _____ ☐ No
- What surgeries have you had <u>ever</u> to your spine, joints, bones; or in the <u>*last year*</u> to any other body part?

_____ Date: _____ Surgeon:_____

_____ Date: _____ Surgeon:_____

_____ Date: _____ Surgeon:_____

- Is there any chance you could be pregnant? ☐ **Yes** (Date of last period _____) ☐ No ☐ N/A
- Have you ever been to a chiropractor before? ☐ **Yes** ☐No

Clinic/Dr. Name: _____ Location: _____ Date of last visit: _____

For What Condition: _____

Patient Signature: _____ **Reviewed by:**_____

NOTES:

_____

_____

_____