

Chiropractic Case History

(PLEASE FILL OUT ALL SPACES – IF UNSURE, WRITE “NOT SURE” OR “N/A”)

Today's Date: _____

Name _____ Sex M F Date of Birth _____

Address _____ City _____ State _____ Zip _____

H. Phone _____ W. Phone _____ Email _____ Age _____

Social Security # _____ Marital Status M S D W Employer _____

Insurance Co. _____ Policyholder's Name (Full) _____

Date of Birth _____ Work Phone _____ Policyholder's Employer _____

Policyholder's Social Security # _____ Relationship to Policyholder (Spouse, Mom, etc.) _____
(All patients MUST provide a copy of insurance card to office in order for claims to be filed)

YOUR PRIMARY CARE PHYSICIAN (PCP) _____ PHONE _____

Were you referred into our office? Yes No If yes, then who referred you? _____

Is this visit and your complaints due to an accident? Yes No If so, which? AUTO WORK HOME
DATE OF ACCIDENT: _____ ATTORNEY RETAINED? Yes No If so, who _____
If auto accident, who received ticket from police? (Please circle) ME OTHER PARTY NO TICKET ISSUED

*** Please answer the following questions. DO NOT leave blanks. Write 'NO' or 'N/A' when appropriate ***

PLEASE LIST:

Any/all surgeries in your lifetime _____
Circle only those that are relevant to your present complaint(s)

Any/all illness in your lifetime _____
Circle only those that are relevant to your present complaint(s)

Any/all injuries in your lifetime _____
Circle only those that are relevant to your present complaint(s)

Past treatments **ONLY** related to your present complaint(s) _____

Past treatments/surgeries related to the spine or any other joints _____

Past auto accidents (list even if older than 10 years) _____

Current medications _____

Any family member with diseases _____

Your occupation (be specific) _____
Circle if you think your job has a relationship to your present complaint(s)

Your exercise level (circle): None Infrequent Occasional Frequent Excessive Limited (due to injury)

Substance Use (circle and put amount): Alcohol _____ Cigarettes _____ Recreational Drugs _____

PLEASE CIRCLE IF YOU HAVE HAD OR NOW HAVE ANY OF THE FOLLOWING:

Osteoporosis Cancer Bladder Dysfunction Spinal Surgery Blocked Arteries Dizziness Aneurysm

Please list your present COMPLAINTS/PAINS. List them in 1-2-3 order of importance and please circle the same type of problem(s) on the bottom list . It is important to list your problems separately (ex: back pain involving neck and lower back would be two (2) different problems. Please fill out all areas and put 'N/A' if an answer does not apply. Please discuss any additional problems or problems you have, which are not on the bottom list with the doctor during exam.

	Complaint #1	Complaint #2	Complaint #3
Questions About Problems			
(Location) Describe the area of this problem. Include any joints, muscles or parts of the spine.			
(Quality) Are there any parts of your body that you have trouble moving because of this problem? Please explain.			
(Quality) Do you have any radiating pain because of this? If yes, please explain where.			
(Quality) Describe your complaint (ex: burning, sharp, mild, etc.)			
(Duration) When did this problem first appear? Is it constant? If not, how many times during day or week?			
(Timing) Did this problem come from an injury? If so, then provide approximate date.			
(Timing) What activities improve this condition (ex: ice, rest, exercise, medication)			
(Timing) What activities make this condition worse? (ex: long-term standing, twisting, light lifting, etc.)			
(Modifying) Have any medications helped control this problem or not? If so, please list.			

Musculoskeletal

CHIEF COMPLAINT LIST OF PROBLEMS (please circle):

Neurological

- Arthritis Burning Sensation Loss of Motion
- Muscle Spasm Muscle Weakness Numbness
- Scoliosis Tingling (arm/leg) Stiffness
- Neck Pain Low Back Pain Mid Back Pain
- Joint Pain (knees, shoulders, wrist, etc.) Herniated Disc

- Dizziness Problems Walking Headaches
- Hearing Numbness Shooting Pain
- Post-Stroke Incontinence Equilibrium
- Loss of Feeling Radiating Pain Twitching
- Back/Neck Pain post spinal surgery