Case History

Name____Sex M F
Date_______________________________________

Address___________________________________City_______________________
State_________________Zip___________________

H. Phone(________)___________________W. Phone____________________ Date of Birth__________________
Age___________

Referred by______________________________Social Security #____________________________________

Occupation____
Employer____

Primary reasons for seeking care:

Primary reason:
____

Secondary reason:
____

Other factors contributing to the primary and secondary reasons:
____

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?
____

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Does anything aggravate the complaint?
____

Does anything make the complaint better?
____

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

____

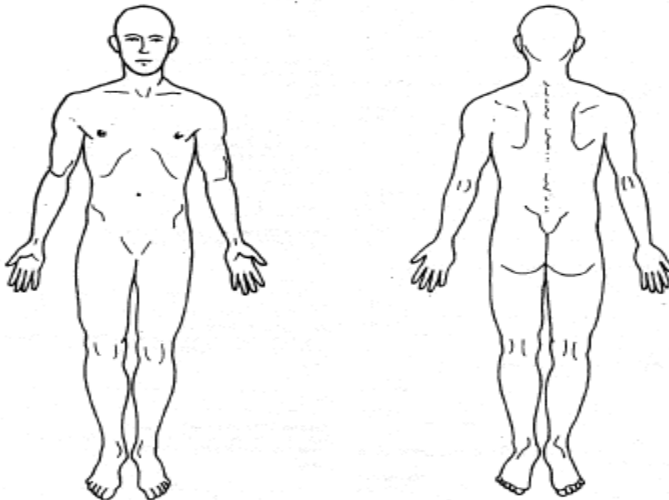
____

SEVERITY OF PAIN

List the area of pain and circle the number below to describe the amount of pain with "1" indicating minor discomfort and "10" representing severe pain.

1. _________________________ 1 2 3 4 5 6 7 8 9 10
2. _________________________ 1 2 3 4 5 6 7 8 9 10
3. _________________________ 1 2 3 4 5 6 7 8 9 10
4. _________________________ 1 2 3 4 5 6 7 8 9 10
5. _________________________ 1 2 3 4 5 6 7 8 9 10

Please mark areas of pain on the drawings using the code listed.
burning (+++) stabbing (000) sharp (---) aching (///)



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Please list any concerns about your symptoms and anything you would like the doctor to know____

____

Habits

Smoking: Packs per day _____

Alcohol: Drinks per day ____

Coffee/Tea: Cups per day ____

Vitamins/herbs (list all being taken):

____

List any broken bones or dislocations: ____

Have you ever had a spinal tap or injection? __ Yes __ No

Have you even been knocked unconscious? __ Yes __ No

Have you ever had a lapse in memory? __ Yes __ No

Have you ever had x-rays, MRI or CAT Scan of your spine? __ Yes __ No When? ________________

Do you suffer from any condition other than that for which you are consulting us?______________________

Are you presently taking any prescription medication? __ Yes __ No If yes, please list:

____

____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic and or acupuncture and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _______________________________ Date: ___________

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