



CONFIDENTIAL CHIROPRACTIC CASE HISTORY

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Legal Name: _____

How do you wish to be addressed in our office? _____

Address: _____ City: _____

Postal Code: _____ Phone: _____ Business Phone: _____

Date of Birth: dd____mm____yr_____ e-mail address: _____

Employer: _____ Address: _____

Occupation: _____ Hobbies: (What occupies your spare time?) _____

Emergency Contact Name: _____ Phone: _____

How did you hear about our office? _____

Medical Doctor's Name: _____

Would you like a medical report forwarded to your MD? Yes No

I consent to the clinic to communicate electronically with me for the purpose of scheduling appointments, appointment confirmations, clinic updates and newsletters. Yes No

HEALTH INFORMATION

Have you ever been to a chiropractor before? No Yes, Doctor's Name: _____

When was your last visit? _____ What was the problem? _____

Have you had previous healthcare for this problem? Yes No

Where? _____ When? _____

Were x-rays taken? _____

REASON FOR CONSULTING OUR OFFICE

What is your major complaint? _____

Is this complaint a result of a motor vehicle accident? No Yes

Is this a Workers' Compensation case? No Yes

How long have you had this condition? _____

Have you had this or similar conditions in the past? No Yes, and when? _____

What activities aggravate your condition? _____

What makes it better? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes _____

Is this condition interfering with your Work Sleep Daily Routine Other _____

(Please complete both sides)

How long has it been since you really felt well? _____

Has there been any medical diagnosis of your complaint? No Yes, if yes list the Dr.'s name and diagnosis: _____

List surgical operations and years: _____

List any Prescription Drugs, Over the counter Drugs, Vitamins and Natural Supplements you are currently taking: _____

Age of Mattress: _____ Comfortable: Yes No

Do you wear: Heel Lifts Sole Lifts Inner soles Arch supports Orthotics

Have you been in an auto accident: Never Past year Past 5 years Over 5 years

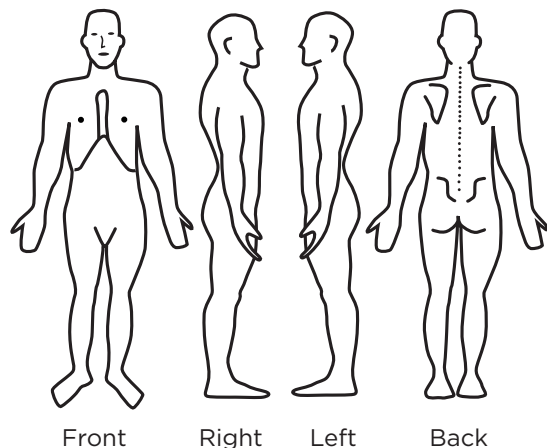
Description of accident: _____

Have you had any other personal injury or accident: None Past year Past 5 years Over 5 years

Description of accident: _____

Date of most recent physical examination: _____

Please mark the areas of pain and/or discomfort on the figures below:



Please rate your current level of discomfort:

	No Pain	Moderate Pain	Unbearable Pain
Neck:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10		
Mid Back:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10		
Low Back:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10		

Are you affected by any of the following?

Please check O = Occasionally F = Frequently C = Constantly NA = Not Applicable

	O	F	C	NA		O	F	C	NA		O	F	C	NA
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gynecological Conditions:				
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____				
Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
											Due date: _____			

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ Dated: _____

Patient consent for examination _____

Doctor's Initials