Dr. Ken Brough
Dr. Melissa Baird
Dr. Kate Higgins

CURAVITA
Chiro • Massage • Physio

Date: ______________________

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: ____________________

____

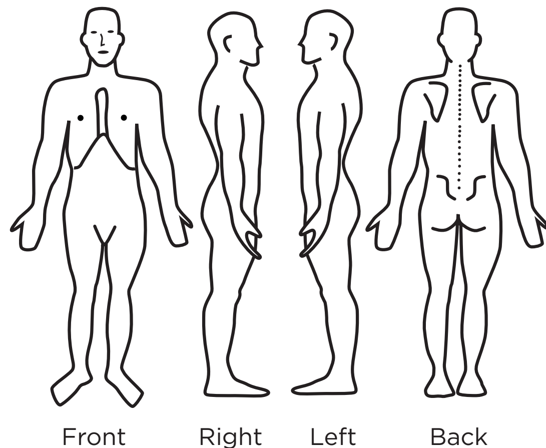
Have you had any other personal injury or accident: ❏ None ❏ Past year ❏ Past 5 years ❏ Over 5 years

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	❏	❏	❏	❏	Headaches	❏	❏	❏	❏	Dizziness	❏	❏	❏	❏
Low Back pain	❏	❏	❏	❏	Sinus Trouble	❏	❏	❏	❏	High blood pressure	❏	❏	❏	❏
Neck pain	❏	❏	❏	❏	Digestive Upset	❏	❏	❏	❏	Gynecological Conditions:				
Allergies	❏	❏	❏	❏	Constipation	❏	❏	❏	❏	Describe: ____________				
Earache	❏	❏	❏	❏	Heartburn	❏	❏	❏	❏	____________				
Sore Throat	❏	❏	❏	❏	Migraines	❏	❏	❏	❏	Pregnant? Yes ❏ No ❏				
										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