



### 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

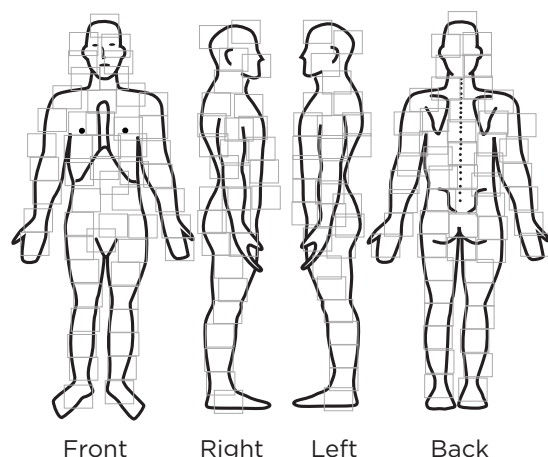
Description of accident: \_\_\_\_\_

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 |
|------------------|------------------------|---------------|-----------------|
| <b>Neck:</b>     | 0-1-2-3-4-5-6-7-8-9-10 |               |                 |
| <b>Mid Back:</b> | 0-1-2-3-4-5-6-7-8-9-10 |               |                 |
| <b>Low Back:</b> | 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                       |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Asthma        | <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"/> |
| Neck pain     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Earache       | <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"/> |

|                 | O                        | F                        | C                        | NA                       |
|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Headaches       | <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"/> |
| Digestive Upset | <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"/> |
| Heartburn       | <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"/> |

|                           | O                            | F                           | C                        | NA                       |
|---------------------------|------------------------------|-----------------------------|--------------------------|--------------------------|
| Dizziness                 | <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"/> |
| Gynecological Conditions: |                              |                             |                          |                          |
| Describe: _____           |                              |                             |                          |                          |
| 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