



Confidential Case History (Chiropractor)

Patient Name: _____ Date: _____

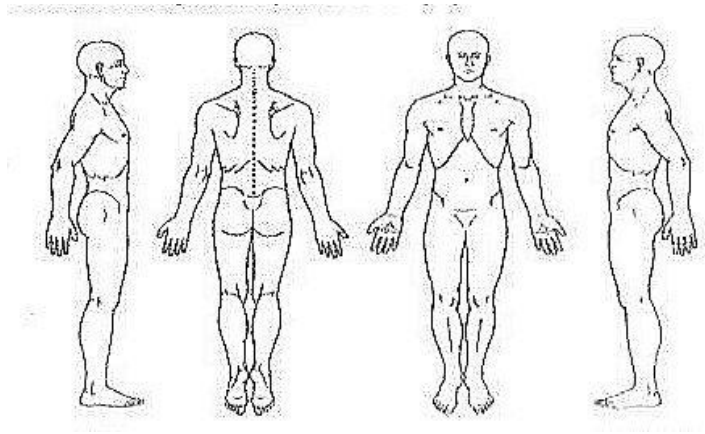
When did your symptoms start? _____

Describe your symptoms and how they began: _____

How often do you experience your symptoms?

- Constantly (76 - 100% of the day)
- Frequently (51 - 75% of the day)
- Occasionally (26 - 50% of the day)
- Intermittently (0 - 25% of the day)

Indicate where you have pain or other symptoms:



What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling

How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

How bad are your symptoms at their: none unbearable

	worst:	0	1	2	3	4	5	6	7	8	9	10
	best:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
<i>no complaints</i>		<i>mild, forgotten with activity</i>		<i>moderate, interferes with activity</i>		<i>limiting, prevents full activity</i>		<i>intense, preoccupied with seeking relief</i>		<i>severe, no activity possible</i>

What activities make your symptoms worse? _____

What activities make your symptoms better? _____

Who have you seen for your current symptoms? No one Medical Doctor Massage Therapist
 Chiropractor Acupuncturist Other

When and what treatment? _____

What tests have you had for your symptoms and when were they performed?

X-Ray: _____ (date) MRI : _____ (date) CT Scan: _____ (date) Other: _____ (date)

Have you had similar symptoms in the past? Yes No

If you have received treatment in the past for the same or similar symptoms, who did you see? This office Medical Doctor Other
 Chiropractor Acupuncturist Massage Therapist

What do you hope to get from your treatment? (select all that apply):

- Reduce symptoms
- Resume/ increase activity
- Explanation of condition
- Learn how to care for this on my own
- How to prevent this



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Name: _____ Date: _____

What type of regular exercise do you perform? None Light Moderate Strenuous

What is your height and weight? Height: _____ Weight: _____

For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present	Past	Present	Past	Present			
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/use of tobacco products
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	Females Only:		
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Tumor			
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus Other: _____

List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and the times you have been hospitalized:

Authorization

I certify that I have read, understand and accurately answered the above information to the best of my knowledge. I understand that omitting information or providing inaccurate information can be dangerous to my health.

Patient signature: _____

Date: _____

Doctor/Therapist signature: _____

Date: _____