

**CONFIDENTIAL PATIENT CASE HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS #: \_\_\_\_\_ Marital Status: M S W D  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Name of significant other: \_\_\_\_\_ Occupation: \_\_\_\_\_ Number of children: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 In case of an emergency, who should we contact: \_\_\_\_\_ Phone: \_\_\_\_\_

<p><b>How did you hear about our office? / Whom may we thank for sending you hear?</b></p> <p>Personal referral: _____          Doctor referral: _____          Phone Book: ___ w/ Bobcat on front                            ___ w/ Ram on front                            ___ Dex yellow book                            ___ Yellow Pages          Internet: (search engine): _____</p>	<p><b>Would you like to register your email address and receive our newsletters and bulletins by e-mail?</b>          ___ YES ___ NO</p> <p>Email address: _____</p> <p>These letters provide health information about our clinical services and new publications. Email addresses are strictly confidential and are never given out to other sources. We believe in a no Spam policy.</p>
--	--

Present reason for consulting this office: (please check all that apply):

\_\_\_\_\_ Pain, Symptoms, Illness, or Disease  
 \_\_\_\_\_ Wellness and Preventive Care  
 \_\_\_\_\_ Maximizing personal health potentials  
 \_\_\_\_\_ Improving family and / or community health

**General Systems Review**

**Medications or Supplements** – Are you on any medications or supplements?      **YES**      **NO**  
 (If yes, list all)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Surgeries** – Have you had any recent (in the past 5 years) surgeries?      **YES**      **NO**  
 (If yes, list all)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Laboratory or Diagnostic Findings** – Have you had any laboratory or diagnostic findings from another physician’s related to this condition?      **YES**      **NO**  
 (If YES, please list which tests have been taken, and the results of these examinations. You may use the back of this page if necessary.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other relevant information pertaining to this case.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HEALTH INFORMATION:**

Have you had previous chiropractic care? YES NO

Where? \_\_\_\_\_ When? \_\_\_\_\_ Why? \_\_\_\_\_ X-rays taken? YES NO

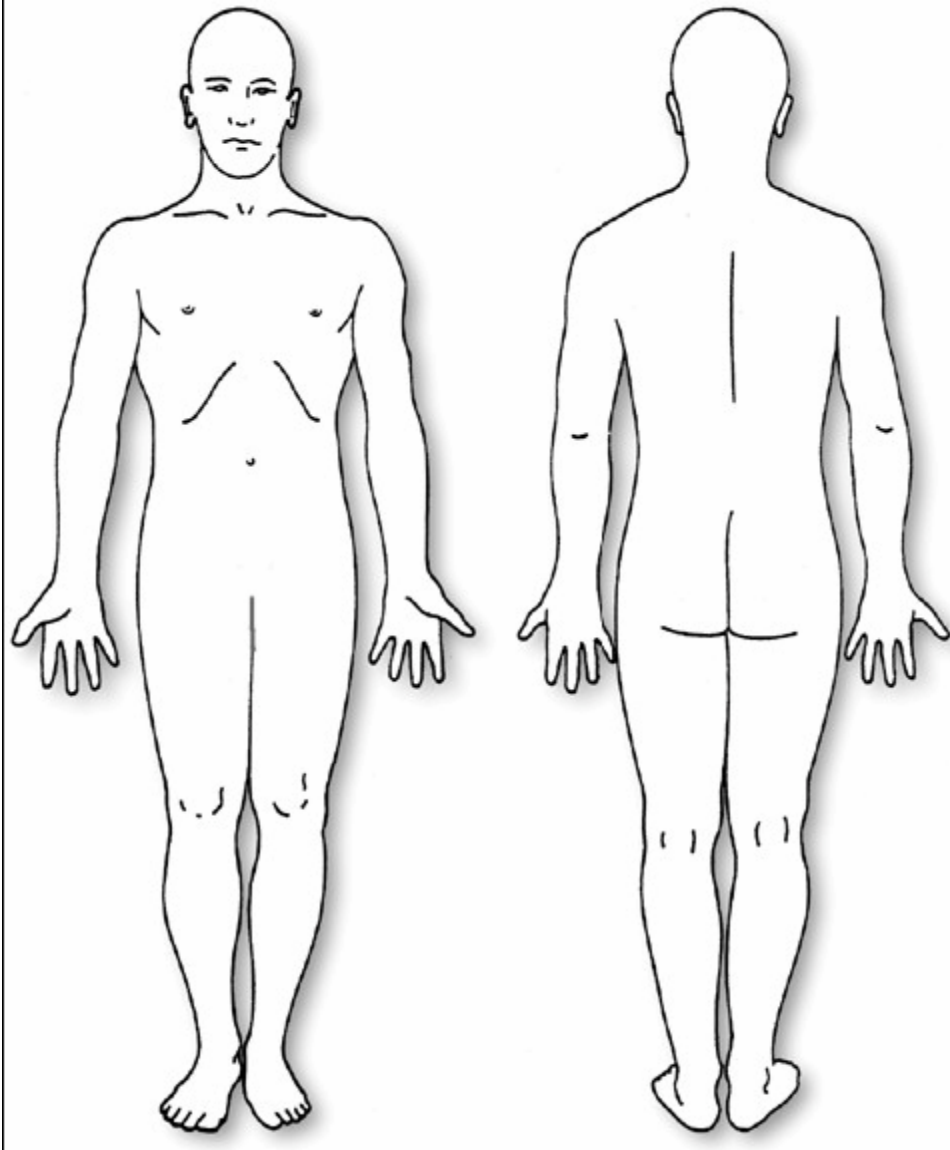
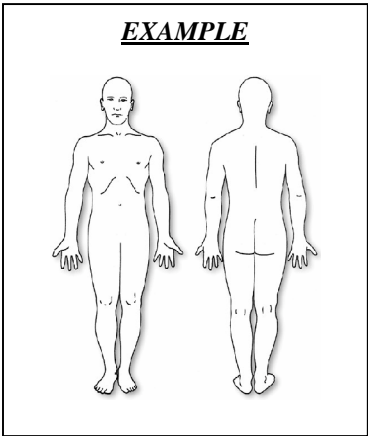
**CHIEF COMPLAINTS**

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• What is your <b>major/presenting</b> complaint?<br/>(Please provide an exact description)</li><br/><li>• Describe the <b>onset</b> of this condition. Is your complaint related to a fall, an accident, or an auto accident?</li><br/><li>• How long have you had this condition? What is its <b>frequency</b>?</li><br/><li>• Do you have a <b>history</b> of similar conditions in the past?</li><br/><li>• Is the condition getting:<br/>    ___Worse ___Same ___ Better<br/>    ___ Consistent ___Recurring</li><br/><li>• How does the condition interfere with your work or activities of daily living?</li><br/><li>• Is there a particular time of day when your condition is worse?<br/>    ___Morning ___Afternoon ___Evening<br/>    ___During the night<br/>    ___After long periods of activity</li><br/><li>• Is this an <b>auto accident case</b>, or have you recently been in an accident? ___ YES (Please explain) ___ NO</li><br/><li>• Is this a <b>workman's compensation</b> case?<br/>    ___ YES (Please explain) ___ NO</li></ul> | <ul style="list-style-type: none"><li>• How would you describe the <b>pain</b> that you are experiencing?<br/>    ___ Persistent ___ Intermittent<br/>    ___ Aching/Throbbing ___ Tingling<br/>    ___ Numbness ___ Burning ___ Shooting<br/>    ___ Radiating pain ___ Other, please explain<br/>    _____</li><br/><li>• What <b>aggravates</b> your condition?</li><br/><li>• What <b>relieves</b> your condition?</li><br/><li>• What types of <b>treatment</b> have you received for this condition? Please list and detail.</li><br/><li>• Please provide the names of other <b>doctors</b> that you have seen for this condition?</li><br/><li>• What was the <b>duration and frequency</b> of previous treatment for this condition?</li><br/><li>• What were the <b>results</b> of previous treatments?<br/>    ___ Poor ___ Fair ___ Good ___ Excellent<br/>    ___ Other, please explain _____</li><br/><li>• <b>Secondary Complaints:</b> What other conditions are you presently being treated for?</li></ul> |
|---|---|

**\*PLEASE NOTE:**

**If you have been in an auto accident please fill out our motor vehicle accident report. This can be downloaded from our website and is available at our front desk.**

# Pain Diagram



Please number the areas where you are experiencing pain or discomfort, according to the following pain scale.

Number Listing	Amount of pain or discomfort you are experiencing
<b>0</b>	No pain or discomfort.
<b>1, 2, 3</b>	The pain or discomfort is an annoyance.
<b>4, 5, 6</b>	The pain or discomfort interferes with activities.
<b>7, 8, 9</b>	The pain or discomfort prevents me from performing certain activities.
<b>10</b>	The pain or discomfort sends me to the emergency room.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_