

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe any Secondary Complaints: _____

Describe WHEN and HOW this began: _____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? (Describe) _____

For this CURRENT condition, have you:

• Received any other treatment? None / DC / MD / PT / Massage / ER / Other: _____ Where? _____

• Had any diagnostic testing? X-rays / MRI / CT / Other: _____ When and Where? _____

HEALTH HISTORY - (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications and Supplements:

Allergies to Medications: **NONE**

Name	Reaction

Current Medications & Supplements: **NONE**

Name	Dosage	Frequency	Method

Past Health History: (Please list any past...)

Number of Falls in the last 24 months: _____ Injuries? Y or N

Surgeries: **NONE**

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: **NONE**

Date	Describe

Patient No: _____

Family Health History:

N/A

List relevant major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education: High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

Are you currently experiencing any of these symptoms? (Check all that apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- ☐ Recent Weight Change
☐ Fever
☐ Fatigue
☐ None in this Category

Musculoskeletal:

- ☐ Low Back Pain
☐ Mid Back Pain
☐ Neck Pain
☐ Arm Problems _____
☐ Leg Problems _____
☐ Painful Joints
☐ Stiff/Swollen Joints
☐ Sore/Weak Muscles or Joints
☐ Muscle Spasms/Cramps
☐ Broken Bones _____
☐ Other: _____
☐ None in this Category

Neurological:

- ☐ Numbness or tingling sensations
☐ Loss of Feeling
☐ Dizziness or light headed
☐ Frequent or Recurrent Headaches
☐ Convulsions or seizures
☐ Tremors
☐ Stroke
☐ Other: _____
☐ None in this Category

Mind/Stress:

- ☐ Nervousness
☐ Depression
☐ Sleep Problems
☐ Memory Loss or Confusion
☐ Other: _____
☐ None in this Category

Genitourinary:

- ☐ Sexual Difficulty
☐ Kidney Stones
☐ Burning/Painful Urination
☐ Change in force/strain w Urination
☐ Frequent Urination
☐ Blood in Urine
☐ Incontinence or Bed Wetting
☐ Other: _____
☐ None in this Category

Gastrointestinal:

- ☐ Loss of Appetite
☐ Blood in Stool
☐ Change in Bowel Movements
☐ Painful Bowel Movements
☐ Nausea or Vomiting
☐ Abdominal Pain
☐ Frequent Diarrhea
☐ Constipation
☐ Other: _____
☐ None in this Category

Cardiovascular & Heart:

- ☐ Chest Pains
☐ Rapid or Heartbeat changes
☐ Blood Pressure Problems
☐ Swelling of Hands, Ankles, or Feet
☐ Heart Problems
☐ Other: _____
☐ None in this Category

Respiratory:

- ☐ Difficulty Breathing
☐ Persistent Cough
☐ Coughing Blood
☐ Asthma or Wheezing
☐ Lung Problems
☐ Other: _____
☐ None in this Category

Eyes and Vision:

- ☐ Wear contacts/glasses
☐ Blurred or double vision
☐ Glaucoma
☐ Eye disease or injury
☐ Other: _____
☐ None in this Category

Ears, Nose and Throat:

- ☐ Bleeding gums / mouth sores
☐ Bad Breath or bad taste
☐ Dental Problems
☐ Swollen throat or voice change
☐ Swollen glands in neck
☐ Ringing in the ears
☐ Ear - Ache/Ringing/Drainage
☐ Sinus / Allergy problems
☐ Nose Bleeds
☐ Hearing Loss
☐ Other: _____
☐ None in this Category

Endocrine, Hematologic, and

Lymphatic:

- ☐ Thyroid problems
☐ Diabetes
☐ Excessive Thirst or urination
☐ Cold Extremities
☐ Heat or Cold intolerance
☐ Change in hat or glove size
☐ Dry skin
☐ Glandular or hormone problem
☐ Swollen Glands
☐ Anemia
☐ Easily Bruise or Bleed
☐ Phlebitis
☐ Transfusion
☐ Immune system disorder
☐ Other: _____
☐ None in this Category

Skin and Breasts:

- ☐ Rash or Itching
☐ Change in Skin Color
☐ Change in hair or nails
☐ Non-healing sores
☐ Change of appearance of a mole
☐ Breast Pain
☐ Breast Lump
☐ Breast Discharge
☐ Other: _____
☐ None in this Category

Women Only:

Are you pregnant?

- ☐ Yes - Due Date ____/____/____
☐ No - Last Menstrual Period ____/____/____

- ☐ Infertility
☐ Painful or Irregular periods
☐ Vaginal Discharge
☐ Other: _____
☐ None in this Category

Pregnancies:

Date	Outcome

Comments: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

Patient No: _____