

Pt. #: _____

Case History

Name (print): _____

Date: _____

I have no symptoms and I just want to have my spine examined (skip to next page)

Below, list the symptoms you are having. Begin with the symptom that hurts / troubles you the most- then go down the list until you have listed all of your symptoms.*

Put a number on each symptom (1-10)
1= "barely hurts"
10=the worst pain you've ever had

When did this symptom begin?
(Please give exact dates when possible)

1. _____

Date Began: _____

Constant

Comes and Goes

2. _____

Date Began: _____

Constant

Comes and Goes

3. _____

Date Began: _____

Constant

Comes and Goes

4. _____

Date Began: _____

Constant

Comes and Goes

5. _____

Date Began: _____

Constant

Comes and Goes

Other Symptoms/Condition: _____

▪ I feel (CIRCLE ONE) Pain / Numbness in my: Rt. Arm Lt. Arm Rt. Leg Lt. Leg Headaches N/A

▪ How far down the arm or leg does the pain go? _____

▪ In general, is your condition getting: Better Worse Same

▪ What do you think caused this condition? Automobile accident Unknown Date of Incident _____

Other: _____

▪ What activity, position, or time of day seems to make your symptoms worse?

▪ What activity, position, or time of day seems to make your symptoms better?

List all the doctors you have seen for this condition, or for any condition if it was *within the last year*:

Doctor/Office *

Location

Date Last Seen

1. _____

2. _____

3. _____

▪ Other than this episode- Have you had a condition like this before? Yes When: _____ No
What treatment did you have and by whom? _____

What were the results?: Good Temporary Didn't help Other: _____

*ASK RECEPTIONIST FOR SEPARATE SHEET IF NEEDED

(OVER)

Are you currently taking medications: Yes No

List Medication*:

For What Condition?

1. _____

2. _____

3. _____

4. _____

Do you take Vitamins? Yes List: _____ No

CHIROPRACTIC MAY SOMETIMES HELP SOME OF THE FOLLOWING CONDITIONS, OR THEY CAN AFFECT YOUR SPINAL CONDITION AND HEALING TIME. CHECK THOSE THAT APPLY TO YOU.

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Where: _____
<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder/Bowel Control	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	Permanent Disability Rating _____%
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Do you smoke?: Yes: (How Much) _____ No

Do you drink alcohol? Yes: (How Much) _____ No

Do you drink coffee/tea/caffeinated drinks? Yes: (How Much) _____ No

Do you take birth control pills? Yes No

Do you sleep on a Mattress Waterbed (We do not recommend waterbeds- ask the doctor)

As a child, did you have any falls or injuries that could have affected your current spinal condition? No

Yes Details: _____

Do you have any hobbies that strain your spine? Golf Bowling Needlepoint Horses Reading in Bed

Other: _____

Have you ever had any accidents, falls, auto accidents, etc. that could have contributed to your current condition?

Yes No Details: _____

What surgeries have you had ever to your spine, joints, bones; or in the last year to any other body part?*

_____ Date: _____ Surgeon: _____

_____ Date: _____ Surgeon: _____

_____ Date: _____ Surgeon: _____

Is there any chance you could be pregnant? Yes (Date of last period _____) No Not Applicable

Have you ever been to a chiropractor before? Yes No

If Yes: Clinic/Dr. Name: _____ Location: _____ Date of last visit: _____

For What Condition: _____

Patient Signature: _____ Reviewed by: _____

NOTES:

