CASE HISTORY

Full Name:_____ **Today's Date:**_____

Birth Date:_____ **Age:**_____ **Sex:** ☐ **Male or** ☐ **Female**

Chief Complaint: 1. _____

2. _____

3. _____

4. _____

Are your present problems due to an injury? ☐ **Y or** ☐ **N** **If yes, please check all of the below boxes that apply to you.**

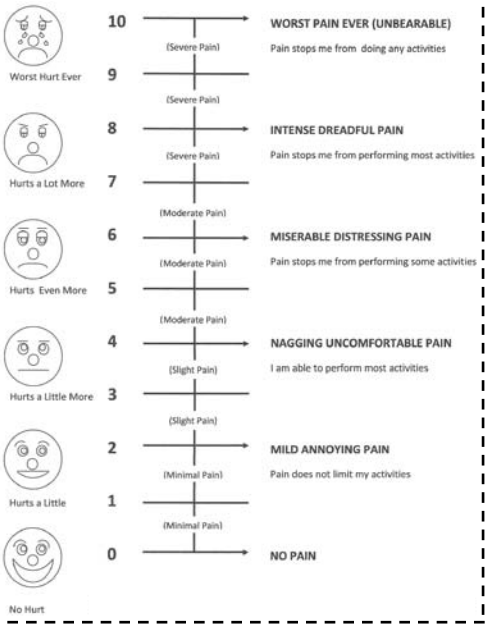
☐ **Occurred on the job** ☐ **Due to Auto Accident** ☐ **Personal Injury Case** ☐ **Other Reason** _____

Injuries have been reported to: ☐ **Employer** ☐ **Workers' Comp.** ☐ **Auto Carrier** ☐ **Police**

Have you retained an attorney? ☐ **Y or** ☐ **N**

Are you now or have you ever been disabled? ☐ **Y or** ☐ **N** **If so, when?** _____

Pain Scale Key



Severity of Pain

List region of pain and circle severity number (See Pain Scale Key)

1. _____
1 2 3 4 5 6 7 8 9 10

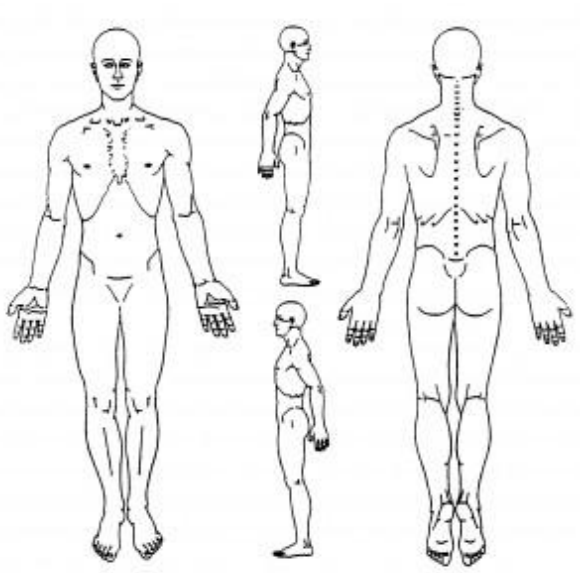
2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

Type of Pain Code (Mark on figure)

+ + +	**Burning**
0 0 0	**Stabbing**
- - -	**Sharp**
ı ı ı	**Tingling/numb**
∧∧∧	**Achy**



Please mark areas of pain on the figures using the code listed above

Habits

☐ **Smoking** **Packs/Day** _____
☐ **Alcohol** **Cups/Day** _____
☐ **Caffeine** **Cups/Day** _____
☐ **Diet Drinks** **Cups/Day** _____
☐ **Illegal/Rx Drugs**

_____

_____

Exercise/Type

☐ **None**
☐ **Moderate**
☐ **Daily**
- ☐ **Dance**
- ☐ **Yoga / Pilates**
- ☐ **Weight Lifting**
- ☐ **Cardio/Aerobics**
- ☐ **Other** _____

Family History

	Cancer	Diabetes	Heart	Kidney	Arthritis	Similar Problem
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐
Sisters, No. of _____	☐	☐	☐	☐	☐	☐
Brothers, No. of _____	☐	☐	☐	☐	☐	☐

Have you had or presently have any of the following conditions?

(Note: if you have Hepatitis, AIDS, or are HIV Positive; you must notify the doctor so he may enact the legally mandated sterilization techniques. Thank you.)

☐ **Arthritis**	☐ **Heart Disease**	☐ **Pleurisy**	☐ **Anemia**	☐ **Venereal Disease**	☐ **Non-listed Diseases**
☐ **Diabetes**	☐ **Herniated Disc**	☐ **Epilepsy**	☐ **Mumps**	☐ **Panic Attacks**	_____
☐ **Thrombosis**	☐ **Hypertension**	☐ **Tuberculosis**	☐ **Measles**	☐ **Anxiety**	_____
☐ **Cancer**	☐ **Whooping Cough**	☐ **Rheumatic Fever**	☐ **Chicken Pox**	☐ **Depression**	_____
☐ **Stroke**	☐ **Appendicitis**	☐ **Goiter**	☐ **Pneumonia**	☐ **Mental Disorder (other)**	
☐ **Polio**	☐ **Stomach Ulcer**	☐ **Osteoporosis**	☐ **Eczema**	_____	

(Continued on other side)

Please check the correct box for each item below. Check at least one box for each of the symptoms listed.

Past	Presently	General Symptoms
☐	☐	Fever
☐	☐	Chills
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Loss of Sleep
☐	☐	Loss of Weight
☐	☐	Loss of Consciousness
☐	☐	Loss of Memory
☐	☐	Nervousness
☐	☐	Headache
☐	☐	Night Sweats
☐	☐	Numbness/Tingling in Arms/Hands/Legs/Feet

Past	Presently	Muscles & Joints
☐	☐	Foot Trouble
☐	☐	Arch Pains
☐	☐	Hand Trouble
☐	☐	Neck Ache
☐	☐	Backache
☐	☐	Spinal Curvature
☐	☐	Stiff Neck
☐	☐	Tail Bone Pain
☐	☐	Swollen Joints
☐	☐	Hernia
☐	☐	Tremors/Twitching
☐	☐	Neuralgia (Nerve Pain)
☐	☐	Weakness
☐	☐	Pain between Shoulder Blades

Past	Presently	Gastro-Intestinal
☐	☐	Belching or Gas
☐	☐	Colon Trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Excessive Hunger
☐	☐	Gall Bladder Trouble
☐	☐	Hemorrhoids (Piles)
☐	☐	Jaundice
☐	☐	Liver Trouble
☐	☐	Nausea
☐	☐	Pain Over Stomach
☐	☐	Poor Appetite
☐	☐	Poor Digestion
☐	☐	Vomiting
☐	☐	Vomiting Blood

Past	Presently	Eye/ear/Nose/Throat
☐	☐	Hay Fever (Allergies)
☐	☐	Poor Vision
☐	☐	Pain in Eyes
☐	☐	Crossed Eyes
☐	☐	Earache
☐	☐	Deafness
☐	☐	Ear Discharge
☐	☐	Ear Noises
☐	☐	Nasal Obstruction
☐	☐	Nose Bleeds
☐	☐	Sinusitis
☐	☐	Tonsillitis
☐	☐	Hoarseness
☐	☐	Sore Throats
☐	☐	Frequent Colds
☐	☐	Enlarged Thyroid

Past	Presently	Cardiovascular
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Poor Circulation
☐	☐	Heart Troubles
☐	☐	Pain Over Heart
☐	☐	Rapid Heart Rate
☐	☐	Slow Heart Rate
☐	☐	Irregular Heart Rate
☐	☐	Strokes
☐	☐	Varicose Veins
☐	☐	Swollen Ankles

Past	Presently	Respiratory
☐	☐	Asthma
☐	☐	Chronic Cough
☐	☐	Wheezing
☐	☐	Difficulty Breathing
☐	☐	Chest pain
☐	☐	Spitting Phlegm
☐	☐	Spitting Blood
☐	☐	Bronchitis

Genito-Urinary

☐	☐	Bed Wetting
☐	☐	Blood in Urine
☐	☐	Frequent Urination
☐	☐	Painful Urination
☐	☐	Kidney Infection
☐	☐	Prostate Trouble
☐	☐	Inability to Control Urine

Past	Presently	Skin or Allergies
☐	☐	Boils
☐	☐	Bruising Easily
☐	☐	Skin Dryness
☐	☐	Eczema
☐	☐	Hives or Allergies
☐	☐	Itching
☐	☐	Sensitive Skin
☐	☐	Skin Eruptions

Allergies
(Please all list below)

_____
_____
_____
_____

Past	Presently	For Women Only
☐	☐	Cramps or Backaches
☐	☐	Excessive Flow
☐	☐	Hot Flashes
☐	☐	Irregular Cycle
☐	☐	Painful Periods
☐	☐	Vaginal Discharge
☐	☐	Pregnant
☐	☐	Miscarriage

Last Gyno-Exam Date _____

Last Pap Smear Date _____

Last Breast Exam Date _____

Operations and Procedures

Date or Age		Date or Age		Date or Age		Date or Age	
_____	Vaccinations	_____	Gall Bladder	_____	Breast Augmentation	_____	Abdominal Surgery
_____	Tonsillectomy	_____	Appendectomy	_____	Neck Surgery	_____	Cesarean Section
_____	Oral Surgery	_____	Rectal Surgery	_____	Back Surgery	_____	Spinal Injects/Taps
_____	Tubes in Ears	_____	Hernia	_____	Sinus Surgery	_____	Other_____
_____	Thyroid	_____	Female Organs	_____	Face Lift	_____	Other_____

☐ **I have never had any operations/surgeries.**

List and Date all Hospitalizations (other than the above): _____

List and date any accidents or falls: ☐ **Dance/Sports** _____

☐ **Vehicular** _____ ☐ **Other** _____

List and date any fractures or dislocations: _____

List and date all X-Ray, MRI, CAT Scan and Bone Scan (Please indicate what ailments they were for.): _____

_____

Are you presently using any prescription or over-the-counter medicines or vitamins? ☐**Y or** ☐**N** **If yes, please list below.**

_____

Do you suffer from any conditions other than that for which you are consulting us? ☐**Y or** ☐**N** **If yes, please list below.**

_____

As evidence by my below signature, I have completed this form to the best of my knowledge and I fully understand that I am seeking a chiropractic consult and that I will not hold this Doctor of Chiropractic responsible for any pre-existing medically diagnosed conditions nor for the diagnosis of any medical conditions.

_____ _____ _____

Patient's/Guardian's Signature **Printed Name** **Date**