



Chiropractic Case History

Date: _____ File # _____
First Name: _____ MI: _____ Last Name: _____
Gender: Male _____ Female _____ Married _____ Single _____ Divorced _____ Widowed _____
E-Mail Address: _____

May we e-mail you regarding your chiropractic treatment, diagnosis, and education? [] no [] yes

Address: _____ City: _____ State: _____ Zip: _____

H. Ph.(____) _____ W. Ph.(____) _____ C. Ph.(____) _____

Social Security# _____ Date of Birth: _____ Age: _____

Spouse's Name: _____ W.Ph (____) _____ C.Ph. (____) _____

Nearest Relative not living with you: _____ H.Ph.(____) _____ C.Ph.(____) _____

Nearest Friend not living with you: _____ H.Ph(____) _____ C.Ph (____) _____

Employer: _____ Occupation: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Whom may we contact in the case of an emergency?
_____ Phone: _____

How were you referred to us (or whom may we thank for your referral)?
_____ Phone: _____

May we publicly thank you for choosing our office by printing your name in our monthly newsletter? [] no [] yes

Who is responsible for this bill? _____

I will be paying today by cash: _____ check: _____ credit card: _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature (parent if under 18 years of age) _____ Date _____

1. Primary reasons for seeking Chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medications	Reasons for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____

F. Females/Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____

5. Family Health History:

Associated health problems or siblings death	Age at death
_____	_____
_____	_____

6. Social and Occupational History:

A. Level of Education

- high school
 some college
 college graduate
 post graduate studies

B. Job description: _____

C. Work Schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

Please check all conditions you currently have or have had:

<p>General Questions</p> <p>0 Weight loss</p> <p>0 Weight gain</p> <p>0 Change in sleep patterns</p> <p>0 Change in activity capacity</p> <p>Neurologic and Psychiatric</p> <p>0 Anxiety</p> <p>0 Headaches</p> <p>0 Depression</p> <p>0 Meningitis</p> <p>0 Paralysis</p> <p>0 Seizure</p> <p>0 Stroke</p> <p>0 Tingling</p> <p>0 Tremors</p> <p>0 Memory Loss</p> <p>0 Fainting spells, dizziness</p> <p>0 Head injuries</p> <p>0 Blackouts or near blackouts</p> <p>0 Change in sensation anywhere on your body</p> <p>0 Localized weakness or numbness</p> <p>Ears, Eyes, Nose & Throat</p> <p>0 Hay fever</p> <p>0 Glaucoma</p> <p>0 Polyps</p> <p>0 Allergy</p> <p>0 Cataracts</p> <p>0 Goiter</p> <p>0 Hoarseness</p> <p>0 Double vision</p> <p>0 Gum problems</p> <p>0 Eye problems</p> <p>0 Ear Infections</p> <p>0 Glasses/contacts</p> <p>0 Hearing Loss</p> <p>0 Ear discharge/pain</p> <p>0 Frequent nosebleeds</p> <p>0 Ringing in your ears Sinus infections</p> <p>0 Swollen glands</p>	<p>Cardiovascular</p> <p>0 Angina 0 Chest pain</p> <p>0 Leg cramps 0 Murmurs</p> <p>0 Ankle swelling</p> <p>0 Awakening at night short of breath & getting out of bed</p> <p>0 Cardiac catheterization</p> <p>0 Cold hands or feet</p> <p>0 Congenital heart defects</p> <p>0 Dizziness when standing up quickly</p> <p>0 Heart attacks</p> <p>0 Heart failure</p> <p>0 High or low blood pressure</p> <p>0 Irregular heart rate</p> <p>0 Purple fingers or lips</p> <p>0 Leg pain that resolves with rest</p> <p>0 Heart palpitations</p> <p>0 Varicose veins</p> <p>Respiratory</p> <p>0 Pleurisy 0 Wheezing</p> <p>0 Asthma</p> <p>0 Breathlessness when lying flat</p> <p>0 Prolonged cough</p> <p>0 Coughing up blood</p> <p>0 Emphysema</p> <p>0 Shortness of breath</p> <p>0 Tuberculosis</p> <p>0 Pneumonia</p> <p>0 Frequent infections (bronchitis)</p> <p>Skin</p> <p>0 Abscess 0 Dandruff</p> <p>0 Acne 0 Oily skin</p> <p>0 Boils 0 Rashes</p> <p>0 Hives 0 Dry skin</p> <p>0 Lumps 0 Psoriasis</p> <p>0 Jaundice</p> <p>0 Athlete's foot</p> <p>0 Excessive body odor</p> <p>0 Excessive sweating</p> <p>0 Fungal infections</p> <p>0 Nail problems</p> <p>0 Moles- irregular</p> <p>0 Moles - change/new</p>	<p>Kidneys & Urinary Tract</p> <p>0 Blood in urine</p> <p>0 Brown urine Dribbling after urination</p> <p>0 Painful urination</p> <p>0 Excessive thirst Involuntary urination/incontinence</p> <p>0 Urinating frequently (day)</p> <p>0 Urinating frequently (night)</p> <p>0 Urine hesitancy Weak flow</p> <p>0 Frequent bladder infections</p> <p>0 Kidney disease</p> <p>0 Kidney stone</p> <p>Endocrine</p> <p>0 Diabetes 0 Sickle cell</p> <p>0 Abnormal body hair</p> <p>0 Changes in skin texture</p> <p>0 Cold intolerance</p> <p>0 Heat intolerance History of "borderline" diabetes</p> <p>0 Increased loss of hair</p> <p>0 Rheumatism</p> <p>0 Thyroid disease</p> <p>Male & Female</p> <p>0 Painful sexual intercourse</p> <p>0 Loss of sexual interest</p> <p>0 Unprotected sex</p> <p>0 Groin itching Sexually transmitted diseases</p> <p>Males Only</p> <p>0 Hernia 0 Sterility</p> <p>0 Bloody ejaculation</p> <p>0 Inability to complete intercourse</p> <p>0 Lump on testicle</p> <p>0 Penile discharge</p> <p>0 Premature ejaculation</p> <p>0 Problems maintaining or keeping an erection</p> <p>0 Prostate disease</p> <p>0 Sores on penis or warts</p> <p>0 Testicular pain</p> <p>0 Testicular swelling</p>	<p>Musculoskeletal</p> <p>0 Anemia 0 Arthritis</p> <p>0 Back pain 0 Bursitis</p> <p>0 Gout 0 Joint aches</p> <p>0 Neck pain 0 Tendinitis</p> <p>0 Abnormal Blood Counts</p> <p>0 Blood clots in legs/lungs</p> <p>0 Bone Marrow Biopsy</p> <p>0 Easy Bleeding</p> <p>0 Easy bruising</p> <p>0 Joint swelling</p> <p>0 Morning stiffness</p> <p>0 Muscle aches</p> <p>Gastrointestinal</p> <p>0 Diarrhea 0 Gallstones</p> <p>0 Reflux 0 Vomiting</p> <p>0 Ulcers 0 Heartburn</p> <p>0 Hepatitis 0 Indigestion</p> <p>0 Abdominal pain</p> <p>0 Anal fissures</p> <p>0 Black tarry stools</p> <p>0 Vomiting blood</p> <p>0 Constipation</p> <p>0 Nausea</p> <p>0 Problems swallowing</p> <p>0 Hiatal Hernia</p> <p>0 Intestinal obstruction</p> <p>0 Liver disease</p> <p>0 Hemorrhoids</p> <p>0 Red blood after bowel movements</p> <p>Females Only</p> <p>0 D + C 0 Hot flashes</p> <p>0 Hernia 0 Fibroids</p> <p>0 Abn. bleeding between cycles</p> <p>0 Abnormal pap smear</p> <p>0 Bleeding after intercourse</p> <p>0 Complications w/ pregnancy</p> <p>0 PMS</p> <p>0 Endometriosis</p> <p>0 Heavy bleeding during cycles</p> <p>0 Discharge from breast</p> <p>0 Ovarian cysts</p> <p>0 Pelvic Inflammatory Disease</p> <p>0 Postmenopausal symptoms</p> <p>0 Vaginal discharge</p> <p>0 Vaginal Dryness</p> <p>0 Vaginal warts</p>
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Provider Notes

Provider Signature

Date