CONFIDENTIAL PATIENT CASE HISTORY

Last Name: _____ First Name: _____

Address: _____City: _____State: _____ Zip:_____

Primary Phone #: _____ Secondary Phone #: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: ____Male ____Female

Social Security #: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Employer Address: _____

By Whom Were You Referred? _____

Emergency Contact (Name and Phone): _____

HEALTH INFORMATION

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ___Yes___ No ___ Constant ___ Comes and goes

Is this condition interfering with your? ___Work ___ Sleep ___ Daily Routine

How long has it been since you really felt good? _____

Other doctors who treated this condition: _____

PAIN LEVEL: On a scale of 0-10, with 0 being pain free and 10 being agony, where would you rate yourself? **0 1 2 3 4 5 6 7 8 9 10**

Other Complaints: _____

List surgical operations and year of procedure: _____

_____

Please list all drugs/medications you are now taking: _____

_____

Do you have any allergies, if so please list and include allergies to any medications: _____

_____

Have you been in an auto accident? ___Past year ___ Past 5 years ___ Over 5 years ___ Never

Please Describe: _____

Have you had any other personal injury or accident? _____ If yes, when _____

Please Describe: _____

Primary Care Physician _____ Phone Number:_____

Date of last physical examination: _____

May we contact your Primary Care Physician regarding this visit? ___No ___Yes

Do you **Smoke? (**Yes/No) Packs per day_____ For how long_____

Drink alcohol? (Yes/No) Drinks per week_____

Use caffeine? (Yes/No) Cups per day _____

Exercise regularly? (Yes/ No) ____Aerobics Class ____Weight Training ____Walk ____Run ____Bike

How often? _____

During the day (work or home) do you ___sit at a desk ___use a computer ____stand in one position

Does your job require you to lift? ____No ____Yes If yes, ____10lbs. ____25lbs. ____50lbs.

Have you ever had any of the following;

Dizziness _____	Backaches_____	Heart Trouble_____
Diabetes _____	Arthritis _____	Headaches _____
Asthma _____	Digestive Disorders _____	Nervousness _____
Sinus Trouble _____	Neck Pain _____	Artificial Bones/Joints_____

Other _____

FAMILY INFORMATION

Has any family member (parents, siblings, grandparents) had any health condition:

Dizziness _____	Backaches_____	Heart Trouble_____
Diabetes _____	Arthritis _____	Headaches _____
Asthma _____	Digestive Disorders _____	Nervousness _____
Sinus Trouble _____	Neck Pain _____	Artificial Bones/Joints_____

Other _____

Have you had previous chiropractic care? ___Yes ___No

If yes, please explain: _____

Please check the type of care you desire to receive in our office, so we may be guided when treatment is discussed: ___ Relief ___Corrective ___Check here if you want the Doctor to select the type of care appropriate for your condition.

Patient's Signature:_____ Date:_____

Guardian's Signature:_____ Date:_____