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CONFIDENTIAL CASE HISTORY FILE

Date: _____

Full Legal Name: _____ Name you prefer: _____

Address: _____City, State, Zip: _____

Phone: (home) _____(cell) _____ (work) _____ Social Security #: _____

Birth Date: _____/_____/_____ Age: _____ Sex: _____ Marital Status: S M W D P

Spouse/Partner Name: _____ Number of Children: _____

Emergency Contact: _____ Relation:_____ Phone: _____

Your Employer: _____ Phone: _____

Email Address: _____ Referred by: _____

MEDICAL HISTORY *(please be complete)*

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accidents (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

_____

List all current over-the-counter and prescription medications used (include reason used):

_____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc)

_____

Have you been under a physician's care in the past year? ☐ No ☐ Yes Reason: _____

Have you ever been under chiropractic care? ☐ No ☐ Yes, describe: _____

If female, is there a possibility that you are pregnant? ☐ No ☐ Yes

Do you smoke/use tobacco? ☐ No ☐ Yes Exercise Habits? ☐ Never ☐ Occasional ☐ Frequent

Check any of the following symptoms you have noticed: (P=Previously, N=Now)

P	N		P	N		P	N	
☐	☐	Headaches	☐	☐	Low back pain	☐	☐	Sensitive to light or sound
☐	☐	Dizziness or Light-Headed	☐	☐	Leg/foot numbness/tingling	☐	☐	Visual or Hearing disturbance
☐	☐	Jaw Pain, clicking, or locking	☐	☐	Leg/foot fatigue/weakness	☐	☐	Memory loss/problems
☐	☐	Pain or difficulty swallowing	☐	☐	Leg pain with walking	☐	☐	Irritability or depression
☐	☐	Neck pain or stiffness	☐	☐	Abdominal pain	☐	☐	Fatigue or Loss of Energy
☐	☐	Shoulder Pain, L R	☐	☐	Nausea or Vomiting	☐	☐	Fainting or Convulsions
☐	☐	Mid back pain	☐	☐	Diarrhea or constipation	☐	☐	Troubled balance/coordination
☐	☐	Chest pain or cough	☐	☐	Blood in urine or stool	☐	☐	Sleep disturbances/problems
☐	☐	Pain/trouble breathing	☐	☐	Difficulty or pain w/ urination	☐	☐	Rashes (face, body, limbs)
☐	☐	Arm/hand numbness/tingling	☐	☐	Difficulty with sexual function	☐	☐	Joint pain or swelling
☐	☐	Arm/hand fatigue/weakness	☐	☐	Abnormal menstrual periods	☐	☐	Pain w/ exertion (stair climb, etc)

HAVE YOU HAD *ANY* OF THE FOLLOWING:

NOW: ☐ Pain worse at night
☐ Constant Pain
☐ Recent bacterial infection (30 days)
☐ Loss of bowel or bladder control
☐ Recent surgery (30 days)

EVER: ☐ History of Cancer
☐ History of IV drug use
☐ History of Blood transfusion

INFORMATION ABOUT YOUR CURRENT CONDITION/COMPLAINTS

What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: ☐ Constant ☐ Intermittent Is your condition getting worse? _____

What activities aggravate your conditions? (list) _____

What activities lessen your symptoms? (list) _____

List all Doctors/therapists/specialists seen for this problem & treatment given:

_____

_____

_____

Have you had: ☐ X-Ray ☐ MRI or CAT scan ☐ EMG ☐ Bone Scan ☐ Blood Work

Who is your family medical doctor: _____

List all home remedies tried for this problem: _____

Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) Work_____ Sleep_____ Normal Daily Routine_____

Have you had symptoms like this before? ☐ No ☐ Yes, describe _____

Regarding your main complaint:

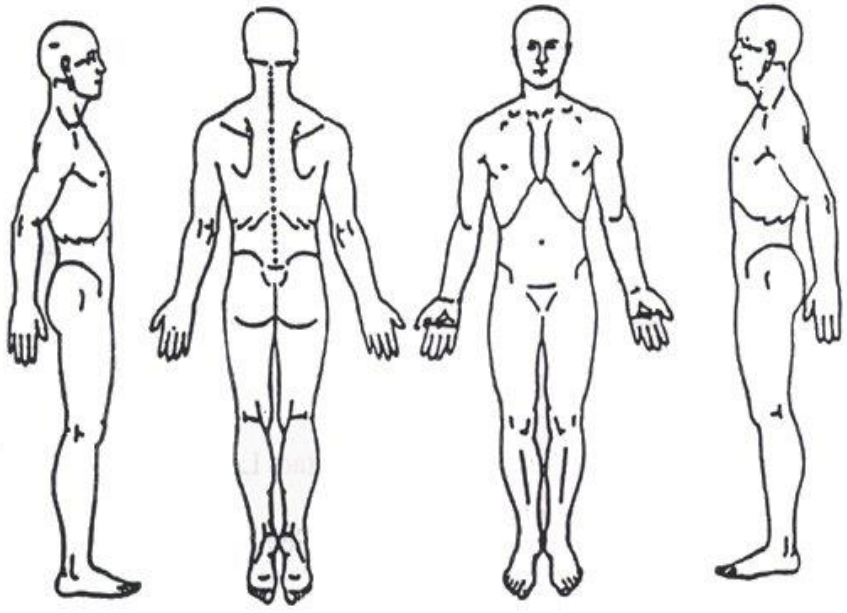
How bad is your pain?
(make a slash on all 3 scales)

1) RIGHT NOW 0 ---------- 10
2) AVERAGE 0 ---------- 10
3) AT WORST 0 ---------- 10

0=no pain **10= worst pain**

Draw the area Of your symptoms Using these symbols:
(mark on the figures)

XXX = Ache
✱ = Sharp/Stabbing
≈≈ = Numbness/Tingling
→→ = Shooting
////// = Stiff/Tight
○○○ = Burning



Patient Signature: _____ Date: _____

Patient Name (printed): _____