

## Chiropractic Case History

Name \_\_\_\_\_ Sex M F Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

H. Phone(\_\_\_\_\_) \_\_\_\_\_ W. Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Referred by \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No

If yes, when & where? \_\_\_\_\_

### 1. Primary reasons for seeking chiropractic care (one body area per complaint):

**Chief complaint:** \_\_\_\_\_

**Second complaint:** \_\_\_\_\_

**Third complaint:** \_\_\_\_\_

**Fourth complaint:** \_\_\_\_\_

Other factors contributing to the primary and secondary reasons: \_\_\_\_\_

#### A. Chief Complaint

Specific location of Complaint: \_\_\_\_\_

Complaint Began when and how? \_\_\_\_\_

Please circle the Quality of the complaint/pain: aching burning deep dull sharp shooting stabbing throbbing other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

#### B. Second Complaint

Specific location of Complaint: \_\_\_\_\_

Complaint Began when and how? \_\_\_\_\_

Please circle the Quality of the complaint/pain: aching burning deep dull sharp shooting stabbing throbbing other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

**C. Third Complaint**

Specific location of Complaint: \_\_\_\_\_

Complaint Began when and how? \_\_\_\_\_

Please circle the Quality of the complaint/pain: aching burning deep dull sharp shooting stabbing throbbing other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

**D. Fourth Complaint**

Specific location of Complaint: \_\_\_\_\_

Complaint began when and how? \_\_\_\_\_

Please circle the Quality of the complaint/pain: aching burning deep dull sharp shooting stabbing throbbing other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

**3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**4. Past & Family Health History**

**A. Previous illnesses you've had in your life:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**B. Previous injury, trauma, or auto accident:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever broken any bones? Which & When? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**C. Allergies** \_\_\_\_\_

**D. Medications:**

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

**E. Surgeries or hospitalizations:**

Date	Type of surgery or reason for hospitalization
_____	_____
_____	_____
_____	_____

**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? \_\_\_\_\_

**G. Family Health History:**

Deaths in immediate family; cause of parents or siblings death:	Age at death
_____	_____
_____	_____
_____	_____

**5. Social and Occupational History:**

**A. Level of Education:**

high school                       some college                       college graduate                       post graduate studies

**B. Job description:** \_\_\_\_\_

**C. Work schedule:** \_\_\_\_\_

**D. Level of physical demand on your body:**    **Low**    **Moderate**    **High**

**E. Rate your Stress level:**    **Low**    **Moderate**    **High**    **Cause:** \_\_\_\_\_

**F. How well do you sleep? How many hours?** \_\_\_\_\_

**G. Do you Exercise? How often? How long?** \_\_\_\_\_

**H. What is your average diet:**    **Fast Food**                      **Restaurants**                      **Ready Meals**                      **Home Cooked**                      **Vegetarian / Vegan**

**I. Do you take any supplements or vitamins?** \_\_\_\_\_

**J. How many bottles (12oz) of water do you drink per day?** \_\_\_\_\_

**K. How many cups of coffee or soda do you drink per day?** \_\_\_\_\_

**L. Do smoke or chow tobacco? How many packs per day?** \_\_\_\_\_

**M. Do you drink? How times per week? Beer, wine, or liquor?** \_\_\_\_\_

**N. Recreational activities:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**O. Is there anything else you would like to discuss?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.**

**Patient or Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**Doctor's Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Doctors Signature** \_\_\_\_\_ **Date** \_\_\_\_\_