Case History

Name ______________________________ Date ______________

Address ______________________________ City ____________ State ______ Zip ______

E-Mail Address ______________________Date of Birth ____________ Age ________

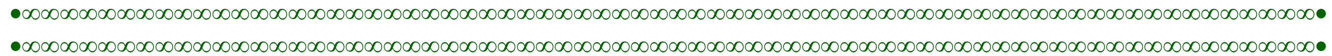
Social Security # ______________ Occupation ____________ Employer ____________

H. Phone (____)__________W. Phone (____)__________Cell Phone (____) ____________

Marital Status: S M D W Spouse's Name ____________Spouse's Occupation____________

Number of Children ______ Age(s)__________Referral Source____________________

Have you ever received Chiropractic Care? ☐ Yes ☐ No



Please check yes or no to answer the following questions pertaining from age 5 through the present, and note any comments in the space provided:

Yes	No		Patient Comments:
☐	☐	Were you taught proper body movement and care?	____________________
☐	☐	Did/do you smoke?	____________________
☐	☐	Did/do you drink any alcohol?	____________________
☐	☐	Diet (Do you eat healthy foods)?	____________________
☐	☐	Have you been in accidents?	____________________
☐	☐	Have you had surgery and organs removed/replaced?	____________________
☐	☐	Drugs? (prescriptive or non-prescriptive)	____________________
☐	☐	Teeth problems?	____________________
☐	☐	Eye problems?	____________________
☐	☐	Hearing problems?	____________________
☐	☐	Exercise regularly?	____________________
☐	☐	Sleeping habits (nightmares)?	____________________
☐	☐	Did/do you have occupational stress?	____________________
☐	☐	Physical stress?	____________________
☐	☐	Mental stress?	____________________
☐	☐	Hobbies/sports injuries?	____________________
☐	☐	Other traumas or problems?	____________________

Sleeping posture ☐ Side ☐ Stomach ☐ Back

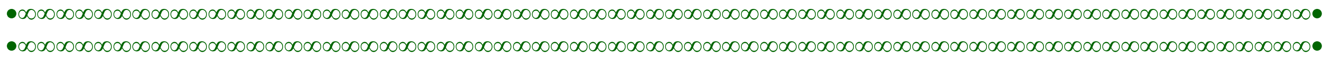
Have you been under drug and medical care? ______________________________
What medications are you taking? ______________________________
How long? ______ Have you had surgery? ______ What? __________ When? __________
What side effects have you experienced from the drugs and /or surgery? ____________________

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other________
Father's Side	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

Case History

What is your primary complaint? ____
Pain or problem started on ____________________ Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent
What activities aggravate your condition/pain? ________________________________
What activities lessen your condition/pain? ___________________________________
Is condition worse during certain times of the day? If yes, when? ______________
Is condition interfering with work? __________ Sleep? __________ Routine? __________ Other? __________________
Is condition getting progressively worse? _____________________________________
Other doctors/remedies tried for this condition ________________________________
Other symptoms:

☐ Headaches	☐ Neck Pain	☐ Sleeping Problems	☐ Back Pain
☐ Nervousness	☐ Tension	☐ Irritability	☐ Chest Pain
☐ Dizziness	☐ Face Flushed	☐ Neck Stiff	☐ Pins & Needles In Legs
☐ Pin & Needles in Arms	☐ Numbness in Fingers	☐ Numbness in Toes	☐ Shortness of Breath
☐ Fatigue	☐ Depression	☐ Lights Bother Eyes	☐ Loss of Memory
☐ Ears Ring	☐ Fever	☐ Fainting	☐ Loss of Smell
☐ Loss of Taste	☐ Diarrhea	☐ Feet Cold	☐ Hands Cold
☐ Stomach Upset	☐ Constipation	☐ Cold Sweats	☐ Loss of Balance
☐ Buzzing in ears			



Do you have Health Insurance? ☐Yes ☐No
Name of Insurance Company________________________________ Phone Number__________________________________
Address of Insurance Company____
Name of Policy Holder____
SS or ID number of insured____
Policy Number/Group Number/Claim Number____

Have you been in an accident? ☐ Yes ☐ No What type? ☐ Work ☐ Auto ☐ Other When? ____________
Nature of accident? _____________________________________ Did you feel popping or tearing in neck or back? _____
Explain ____
Were you hospitalized? ______ Where? _____________________ When? __________ Were x-rays taken? ___________
Have you lost days at work? __________ Dates missed: ____
Is insurance involved? ________ Which company? _______________ Claim # _____________________________
Insurance Address: ____