POMPANO BEACH CHIROPRACTIC CLINIC, P.A.

Family practice since 1951!

4 NE 4th Avenue
Pompano Beach, FL 33060
(954) 943-1044 office
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www.pompanochiro.com

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present. An understanding of your health history will help us to determine appropriate care.

FULL NAME: _____ Date: ____/____/_____

Age: _____ Race: _____ Gender: M F Height: _____Weight: _____ Dominant Hand: R L

Present & Past State of Health (Please circle any current or past symptoms/conditions.)

Muscle & Joint System

C P Neck pain/stiffness
C p Mid back pain/stiffness
C P Tension across shoulders
C P Shoulder Pain L R
C P Scoliosis/spinal curvature
C P Low back pain/stiffness
C P Faulty posture
C P Painful tailbone
C P Arthritis/swollen joints
C P Foot trouble L R
C P Gout

Genito-Urinary System

C P Blood in urine
C P Frequent/painful urination
C P Prostate problems
C P Kidney stones
C P Sexual dysfunction

Females Only

C P Painful menstruation
C P Excessive/irregular flow
C P Cramps or backaches
C P Abnormal discharge
C P Passed menopause
Y N Currently Pregnant?
Y N Miscarriages

General Symptoms

C P Fever/Chills/Sweats
C P Fainting/dizziness
C P Seizures/convulsions
C P Allergies
C P Skin Problems
C P Frequent colds/flu
C P Tremors
C P Loss of balance
C P Unexplained weight loss/gain
C P Anemia
C P Alcoholism
C P Cancer
C P HIV/AIDS
C P Diabetes Type 1/Type 2

Nervous System

C P Headaches/Migraine
C P Numbness/tingling arms/hands
C P Numbness/tingling legs/feet
C P Loss of sleep
C P Poor memory/concentration
C P Learning disability
C P Irritable/nervous/tension
C P Depression/emotional problems
C P Decreased energy/fatigue

Gastrointestinal System

C P Heartburn/Indigestion
C P Ulcers
C P Belching or Gas
C P Nausea or vomiting
C P Pain over stomach
C P Liver trouble
C P Gallbladder trouble
C P Colon trouble
C P Constipation/diarrhea
C P Black/bloody stools
C P Poor appetite

Cardiovascular System

C P Rapid/Slow heart beat
C P High/Low blood pressure
C P Pain over heart
C P Swelling of ankles
C P Poor circulation
C P Previous heart attack
C P Previous stroke

Eyes, Ears, Nose, Throat

C P Deafness/ringing in ears
C P Earaches
C P Sore throat/tonsillitis
C P Thyroid problems
C P Asthma
C P Sinus problems
C P Blurred/failing vision

List any illnesses, surgeries or diseases and what year: _____

_____

Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? O YES O NO

_____

Family History: Place an (X) if any family member has suffered from:

O Tuberculosis O Kidney Disease O Spinal Disorder O Mental Illness O Epilepsy O Diabetes
O Gout O Allergy O Arthritis O Hypertension O Cancer O Heart Attack
O Other, list: _____

_____

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CASE HISTORY….Continued

Daily Living Habits Please indicate which of the following apply

Do you have: O Occupational stress O Emotional Stress
Your diet is: O Balanced O Fair O Poor O Excessive O Restricted

Medications Use/Chemical Stress Drugs taken in the last year and for what condition?

O Pain killers _____ O Birth control pills _____ O Antibiotics _____

O Blood Pressure _____ O Thyroid _____ O Other _____

Do you smoke? O Yes O No If yes, how many years _____ Packs/day_____ Do you drink alcohol? Amount _____

Social History

In what position do you sleep, and how well? _____

Do you exercise on a regular basis? O Yes O No How? _____

PRESENT SYMPTOMS

Primary Complaint: _____

Secondary Complaint: _____

Complaint began when and how? _____

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? _____

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

What aggravates your complaint/pain? _____

What lessens you complaint/pain? _____

What other doctors seen for this complaint: _____

Current Chief Complaint(s): Place an (X) in the appropriate complaint areas. Next to each complaint place a number between 1-10 corresponding to your pain level. 1 = low pain 4-5 = moderate pain 7-9 = intense pain 10 = emergency

SPINE:

O Low Back _____ O Mid Back _____
O Pelvis _____ O Neck _____

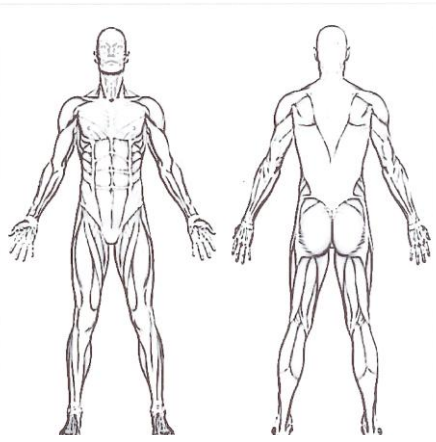
UPPER EXTREMITY:

O Shoulder L/R _____ O Forearm L/R _____
O Wrist L R _____ O Elbow L/R_____
O Arm L /R _____ O Hand L/ R_____

LOWER EXTREMITY:

O Hip L/R _____ O Ankle L/R _____
O Leg L/R _____ O Knee L/R _____
O Thigh L/R _____ O Foot L/ R _____

OTHER (describe): _____



Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X Numbness
O Pins & Needles
+ Burning
= Stabbing

I certify that above information is correct to the best of my knowledge.

Patient Signature _____ ***Date*** _____