Case History

Name _____ Date _____ S.S. # _____

Street _____ City _____ State _____ Zip _____

H. Phone _____ W. Phone _____ Birth Date _____ Age _____ Sex: M F

If female, is there a possibility that you might be pregnant? YES NO Marital Status: M S W D No. of children _____

E-mail address: _____

Occupation _____ Employer _____

Spouse's Name _____ Spouse's Employer/Occupation _____

Who should we call in an emergency? Name _____ Phone _____

List any surgeries (include date) _____

_____

Previous Injuries: _____

_____

Yes	No	**Health Habits**
☐	☐	Do you maintain a good posture?
☐	☐	Do you exercise regularly?
☐	☐	Do you eat 5 or more servings of fruits or vegetables each day?
☐	☐	Do you smoke?
☐	☐	Do you drink 2 or more alcoholic beverages each day?
☐	☐	Do you take nutritional supplements?
☐	☐	Do you consider yourself to be healthy?
☐	☐	Do you frequently feel emotionally stressed?

In the following list, please check all of the conditions that you have experienced in the past year.

HEAD
- ☐ Headache
- ☐ Migraine
- ☐ Head feels heavy
- ☐ Vision problems
- ☐ Dizziness
- ☐ Hearing problems
- ☐ Ringing in ears

NECK
- ☐ Neck pain
- ☐ Grinding sounds in neck

SHOULDERS
- ☐ Pain in shoulders
- ☐ Can't raise arm

ARMS & HANDS
- ☐ Pain in arm
- ☐ Pain in hands
- ☐ Numbness or tingling in arm
- ☐ Numbness or tingling in hands
- ☐ Loss of strength in arms
- ☐ Loss of strength in hands

BACK
- ☐ Upper back pain
- ☐ Mid-back pain
- ☐ Rib pain
- ☐ Pain when breathing
- ☐ Low back pain

ABDOMEN - DIGESTION
- ☐ Nervous stomach
- ☐ Ulcers
- ☐ Constipation
- ☐ Heart burn
- ☐ Hiatal Hernia
- ☐ Nausea

HIPS, LEGS & FEET
- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Pain down upper leg
- ☐ Pain down below knee
- ☐ Pain in both legs
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Numbness or tingling in legs
- ☐ Numbness or tingling in toes
- ☐ Swollen ankles

WOMEN ONLY
- ☐ Menstrual pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Menopause
- ☐ Pre-menstrual Syndrome

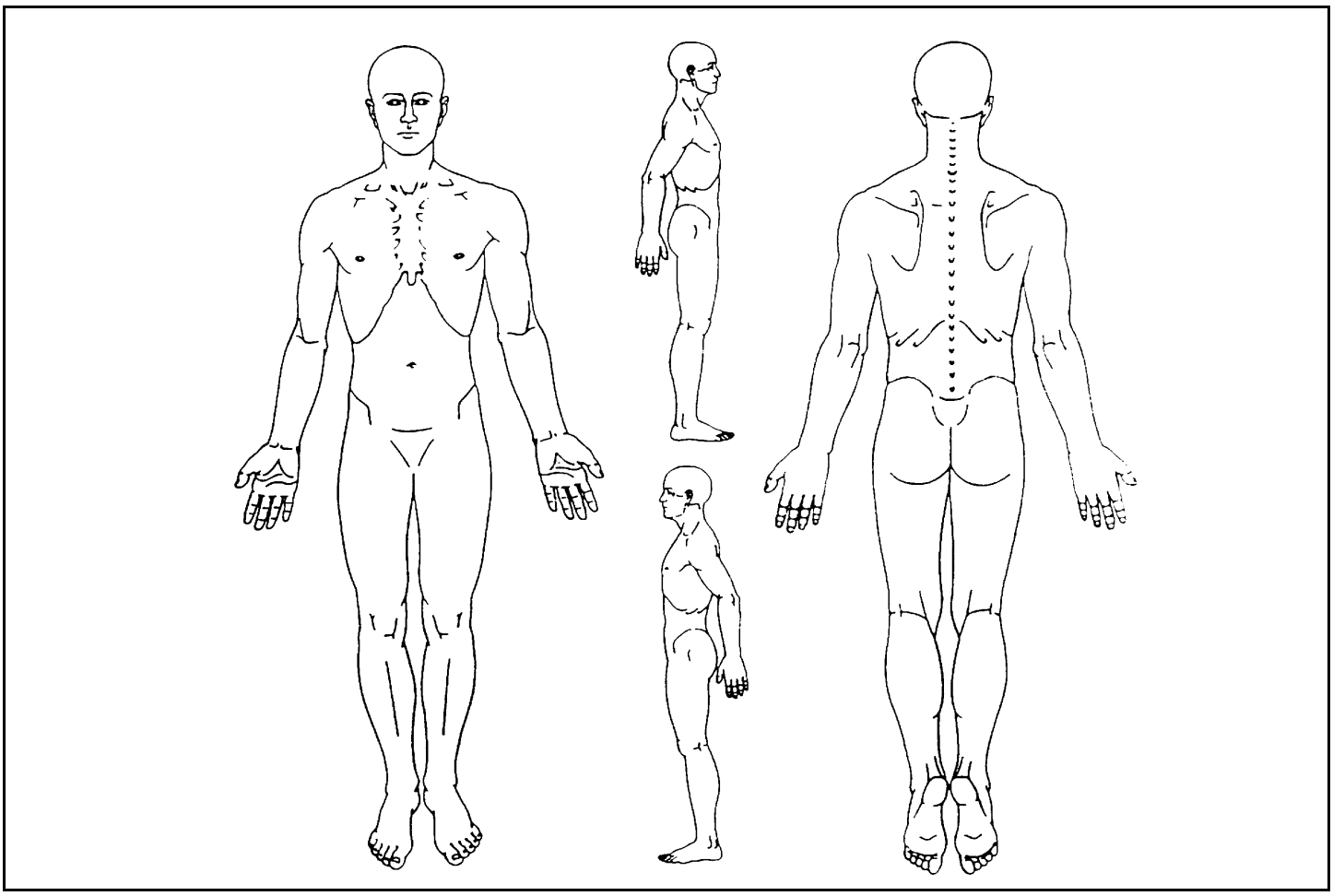
MEN ONLY
- ☐ Urinary frequency
- ☐ Difficulty starting urination
- ☐ Night urination

GENERAL
- ☐ Nervousness
- ☐ Irritable
- ☐ Mood swings
- ☐ Depression
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Diabetes
- ☐ Cancer
- ☐ Breathing problems
- ☐ Asthma
- ☐ Allergies
- ☐ Sinus trouble
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Difficulty losing weight

Other problems: _____

_____

In the box below, please mark the areas of pain or other symptoms.



Have you ever received Chiropractic care? Y / N If yes where?_____

List other doctors consulted for present complaints:

Name _____ When _____ Diagnosis_____Treatment _____

Name _____ When _____ Diagnosis_____Treatment _____

Drugs you now take: _____

Informed Consent: The role of a chiropractor is to help restore function to the spine through chiropractic adjustments. As this is done, most patients experience improvement in spine related conditions. The speed or extent of improvement is to a large degree dependent upon the inherent recuperative abilities of each patient. Some experience very rapid results, some slower results. A small percentage receive no outward benefit. Chiropractic does not treat pain, although most patients do experience reduced pain. Occasionally some patients experience a short-term increase in pain. As with any health care procedure, chiropractic adjustments have some risk. Increased risk often results from some underlying weakness or condition possessed by the patient that is not readily apparent through routine examination. Serious complications to chiropractic adjustments are considered by most authorities to be very rare, occurring once per one million adjustments. By individuals not properly trained, such as lay people and most medical physicians, the risk can be much greater. When evaluating risks and benefits of health care procedures, you must consider the risk of not receiving care. Left untreated, spine function usually deteriorates. Patients who choose medical care rather than chiropractic choose to accept the even greater risks associated with medical care. Prescription drugs cause over 100,000 deaths each year. Over-the-counter drugs also have a poor safety record. Surgery has risks hundreds and even thousands of times greater than chiropractic. Most experts and chiropractic patients agree that the benefits of chiropractic far outweigh the risks, however there are some risks. By signing below you acknowledge that you understand this and agree to continue with your care.

_____ _____

Patient's signature Date

Payment Type:_____

In the next box, describe your major complaint

Referred by:_____

Complaint _____

When did this problem start or when did the most recent occurrence start if you have had it before:

_____

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint. A "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10

How often do you feel symptoms: ☐ Constant, or _____ X per ☐ day, ☐ week, ☐ month, ☐ year.

Have you had similar symptoms in the past? Yes No _____

What activities aggravate this condition _____

Is this condition getting worse? Yes No _____

Is this condition interfering with your: ☐ work ☐ sleep ☐ daily routine ☐ Other _____

Notes _____

If you have a second major complaint please describe it in the next box

Complaint _____

When did this problem start or when did the most recent occurrence start if you have had it before:

_____

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint. A "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10

How often do you feel symptoms: ☐ Constant, or _____ X per ☐ day, ☐ week, ☐ month, ☐ year.

Have you had similar symptoms in the past? Yes No _____

What activities aggravate this condition _____

Is this condition getting worse? Yes No _____

Is this condition interfering with your: ☐ work ☐ sleep ☐ daily routine ☐ Other _____

Notes _____