# VIDA CHIROPRACTIC PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

**List any <u>Surgeries</u>:**

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □

Other:_____

**List <u>ALL</u> <u>Past Medical History</u> conditions:**

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer

□ Chest Pain □ Depression□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy

□ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain □ Genetic Spinal Condition □ Hand Pain

□ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure □ Hip Pain □ HIV □ Jaw Pain

□ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker

□ Parkinson's□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain □ Stroke/Heart Attack □ Other: _____

**List Type of <u>Medications</u> you are taking:**

□ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy

□ Seizure □ Other: _____

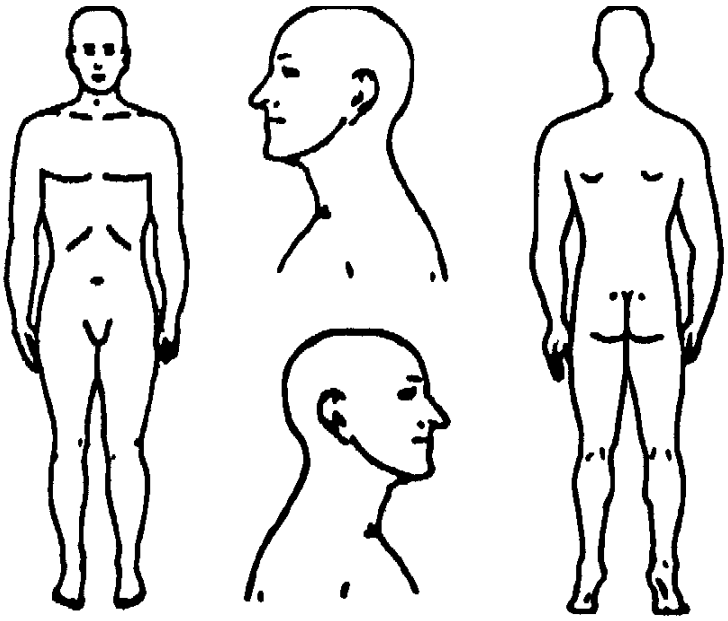
**Have you had any auto or other accidents?** □ No □Yes

Describe: _____

_____

**Date of last Chiropractic visit: _____**

***PLEASE MARK YOUR AREAS OF PAIN AND TYPES OF SYMPTOMS ON THE DIAGRAM BELOW:***



| | | | |
|---|---|---|---|
| + | Tingling | ^ | Stabbing |
| P | Pain | # | Tightness |
| B | Burning | T | Throbbing |
| N | Numbness | R | Radiating pain |
| S | Soreness | * | Sharp pain |
| A | Ache | /// | Shooting |

**MAIN REASON FOR CONSULTING THE OFFICE**

O Become Pain Free

O Explanation of my Condition

O Learn how to care for my condition

O Reduce Symptoms

O Resume normal activity level

**What is your major complaint? _____**

**Date problem began?_____**

**How did this problem begin (falling, lifting,etc.)?_____**

**How is your condition changing?**

□ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

**Have you had this condition in the past?** YES - NO

**How often do you experience your symptoms?**

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

**Describe the nature of your symptoms:**

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:

_____

**Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)**

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**How do your symptoms affect your ability to perform daily activities such as working or driving?**

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**What activities aggravate your condition (working, exercise,etc)?_____**

**What makes your pain better (ice, heat, massage, etc)?**

_____

**What is your second complaint?**

_____

**Date problem began?_____**

**How did this problem begin (falling, lifting,etc.)?_____**

**How is your condition changing?**

□ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

**Have you had this condition in the past?** YES - NO

**How often do you experience your symptoms?**

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

**Describe the nature of your symptoms:**

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:

_____

**Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)**

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**How do your symptoms affect your ability to perform daily activities such as working or driving?**

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**What activities aggravate your condition (working, exercise,etc)?_____**

**What makes your pain better (ice, heat, massage, etc)?**

_____

**What is your third complaint? _____**

**Date problem began?_____**

**How did this problem begin (falling, lifting,etc.)?_____**

**How is your condition changing?**

□ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

**Have you had this condition in the past?** YES - NO

**How often do you experience your symptoms?**

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

**Describe the nature of your symptoms:**

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:

_____

**Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)**

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**How do your symptoms affect your ability to perform daily activities such as working or driving?**

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**What activities aggravate your condition (working, exercise,etc)?_____**

**What makes your pain better (ice, heat, massage, etc)?**

_____

**Have you tried Ice, Heat, or any OTC medications?** Y / N _____

**Have you consulted with any health care provider (Dr, PT, etc) for this condition**: Y / N

_____

_____

**Is this concern work related? Y/ N ...If so, have you reported it to your employer?** Y / N

**Is your daily life affected? (getting out of bed, getting dressed, driving, etc. )** Y / N_____.

***The information in this "Client History" is true and correct, to the best of my knowledge:***

Patient Signature _____ Date: _____

**Chiropractic care is adjustment of joints which are "subluxated," meaning those joints are not in proper alignment or mobility: subluxations interfere with normal blood flow & flow of nerve impulses, messages to/from the brain: subluxations can result in a great variety of unpleasant symptoms, which may include pain, numbness, spasm, loss of mobility, headache, etc.

***At Vida Chiropractic***: **1st**, we scientifically locate your subluxated areas with x-ray, various scans, & assessments. **2nd**, when we have definitely located the subluxations, we treat only those specific areas: avoiding unnecessary adjustment of joints in proper alignment, since unnecessary adjustments can cause subluxation! **3rd**, we encourage regular maintenance of proper alignment, sometimes recommending exercise. As with any treatment, there is risk of unwanted results: within Chiropractic, these are rare, but may include strain or sprain, rib fracture, temporary worsening of symptoms, etc. ***Understanding this information, I wish to receive Vida Chiropractic care, holding Vida Chiropractic harmless if I experience rare, unwanted results:***

Signature_____ Date: _____

***I assume responsibility for any charges created by my Chiropractic Care at Vida:***

Patient Signature _____Date: _____