

Date _____

Chiropractic Case History Form

Name _____ Sex M F Social Security # _____

Address _____ City _____ State _____ Zip _____

Home#(_____) _____ Work# _____ Cell# _____

Date of Birth _____ Age _____ Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed

Email address _____ Would you like to receive our e-mail newsletter? Yes No

Referred by _____ Employer/Occupation _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____ By whom? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging 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 Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes: Please check one **Pregnant** **Not Pregnant**

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

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

6. Social History:

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

7. Insurance:

Blue Cross/Blue Shield Aetna Humana Cigna United Healthcare Medicare Other

A. Insured's Name: _____

B. Policy number: _____

C. Group number: _____

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.

Parent or Guardian Signature _____ Date _____

Patient Signature _____ Date _____