Confidential Case History

Today's Date:_____

Name:_____ Phone:_____

Cell phone:_____ Email:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Occupation:_____

Employer:_____ Work phone:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Age:_____ Male / Female Social Security #:_____

Marital Status:_____ No. of Children:_____ Their ages:_____

Who referred you to our office?_____

Primary Complaint/reason for your visit today?

_____

_____

_____

_____

How long have you had this condition?_____

Can you give a date as to when this occurred? _____

Have you had it in the past? Y N When? _____

Rating of physical discomfort/pain: (10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

Rating of mental/emotional distress associated with this complaint: (10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition? _____

Have you tried anything which has helped? _____

Have you received other treatments for this complaint? _____

Who treated you? _____

What was the outcome? _____

Do you have any secondary complaints?

_____

_____

_____

_____

How long have you had this condition? _____

Can you give a date as to when this occurred? _____

Have you had it in the past? Y N When? _____

Rating of physical discomfort/pain: (10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

Rating of mental/emotional distress associated with this complaint: (10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition? _____

Have you tried anything which has helped? _____

Have you received other treatments for this complaint? _____

Who treated you? _____

What was the outcome? _____

Have you previously had chiropractic or acupuncture? _____

What was your experience? _____

_____

Rate your current general level of health, 10 being ideal:

1 2 3 4 5 6 7 8 9 10

Do you have a family history of: (please circle)

Heart Disease	High Blood Pressure	Diabetes	Cancer
Spinal Problems	Neurological Problems	Arthritis	

Please elaborate:_____

_____

_____

_____

Physical Stress

general physical trauma

Please circle any relevant spinal stress situations that may have occurred in your life:

Childhood falls Falls on ice Physical Abuse Falls down steps/up steps

Knocked unconscious Orthodontic work Extensive dental work

Used crutches, a walker or cane? why?_____

Sports Injuries? please describe:_____

Broken bones? please list:_____

For the above circled, please include relevant details:

_____

_____

_____

_____

_____

daily stress

1. Circle all that apply: During the day, I routinely:

sit stand walk do desk work do mechanical work do heavy lifting

2. I exercise ____ times per week ____irregularly ____not at all

3. What type of exercise are you currently involved in?

_____

_____

4. Do you read for prolonged periods? yes___no___

5. Spend prolonged periods at the computer? yes____no____

6. Do you play a musical instrument? yes___no___
If yes, what instrument(s) do you play? _____

7. Do you watch television for prolonged periods? yes___no___

8. What is your usual sleeping position? back side belly
How many pillows do you use? _____
On average, how many hours do you sleep each night?_____
Do you sleep well? yes___no___
If no, do you have trouble falling asleep____ or staying asleep____?

a u t o a c c i d e n t t r a u m a

1. Have you, even if you do not think you were hurt, been involved in a vehicular collision or near collision?_____

2. Please list the approximate dates of any significant accident(s):

_____

3. Circle the severity of the jolt (5 being the most severe): 1 2 3 4 5

4. What sort of treatment did you seek for any injuries you sustained?

_____

5. Please list any other details that you feel may be relevant:

_____

m e d i c a l t r a u m a

1. Have you ever been hospitalized? yes no
When and for what? _____

2. Have you had surgery? yes no
When and for what? _____

3. Do you have all of your body parts? yes no
If no, what was removed and when? _____

4. Have you had: (please circle)

Spinal tap/epidural injection	Extensive Diagnostic X-rays
Corrective shoes/Orthotics/Heel lift	Neck collar
Spinal brace	Physiotherapy
Blood tests	MRI/CAT Scan

If you circled any of the above, why were such actions performed?

_____

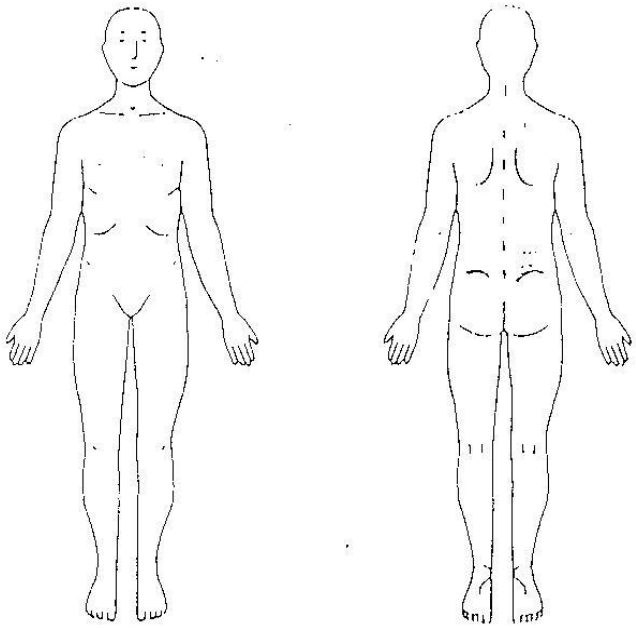
_____

_____

_____

Please mark the areas on your body where you currently feel symptoms. Use the following symbols:

---=numbness xxx=constant throbbing or aches //=sharp twinge 000=sensitivity



Your height_____ Approximate weight_____

Do you experience: (please circle)

Neck Pain	Mood Swings	Skin Problems
Backaches	Anxiety/Depression	Frequent colds/infection
Headaches	Constipation	Menstrual Difficulties
Dizziness	Diarrhea	Menopause symptoms
Arm pain or numbness	Abdominal Bloating	Kidney/Bladder Problems
Leg pain or numbness	Food cravings	Fatigue/Low energy
Allergies/Asthma		Poor concentration

Have you ever been diagnosed with: High blood pressure? YES NO Arthritis? YES NO
Heart trouble? YES NO Diabetes? YES NO

Please include relevant details on any of the above circled.

_____

_____

_____

Chemical Stress

1. Are you now taking any drug (prescription or over the counter) regularly?
yes___no___
If yes, please list.
_____

2. Are these drugs prescribed by a physician? yes___no___
If yes, please list the name and phone number of your physician. _____
_____When was your last visit?_____

3. Were you recently taking any medications regularly that you are no longer taking?
yes___no___
If yes, please list. _____

4. Have you been immunized? yes___no___ transfused? yes___no___

5. Do you work with any chemical, fume, dust, powder, or smoke for prolonged periods?
yes___no___
If yes, please describe the conditions. _____

6. Are you a smoker? yes___no___
If no, were you previously? yes___no___ How long ago did you quit?_____

diet

Do you follow a specific type of diet? _____

Please circle items customarily in your diet.

Red meat	Pasta	Salads/raw vegetables	Plain water
Poultry	Whole grains	Cooked vegetables	Soda/bubbly water
Fish	Legumes	Fruit	Coffee/tea
Dairy	White flour/sugar	Nuts/seeds	Alcohol
Fast foods	Desserts		Artificial flavors or sweeteners

List nutritional supplements you take.

_____

_____

_____

emotional stress

Please circle any emotional stress factors which may be affecting you:

Family problems as a child	Recent change of vocation
Current family problems	Recent change of marital status
Stress in other relationships	Recent change of residence
Frequent or chronic illness	Change in level of physical activity
Work-related stress	Change in sleep habits
Economic stress	Chronic over scheduling/not enough personal time

Is there anything else which may help to better understand you which has not yet been discussed?

_____

_____

_____

What types of treatments are you interested in? (please circle)

Chiropractic	Acupuncture	Cranial work	Nutritional Counseling
Reflexology	Massage	Thai Yoga	

Do you have any other health-related goals that we may be able to help you achieve?

_____

_____

_____

_____