PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

List WORST complaint: _____ How long have you had it?_____

How did it start?_____ Where is the complaint? _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other:

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other:

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other:

Rate complaint on a scale of 1-10 (10 being the worst): _____

Does this complaint radiate/shoot to any areas of your body? No / Yes

If yes, where? _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

How frequent is the complaint present? Off & On / Constant

Which daily activities are being affected by this condition? (Describe) _____

_____

List NEXT WORST complaint: _____ How long have you had it?_____

How did it start?_____ Where is the complaint? _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other:

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other:

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other:

Rate complaint on a scale of 1-10 (10 being the worst): _____

Does this complaint radiate/shoot to any areas of your body? No / Yes

If yes, where? _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

How frequent is the complaint present? Off & On / Constant

Which daily activities are being affected by this condition? (Describe) _____

_____

Explain any of other complaints _____

_____

HEALTH HISTORY

List any condition you have been diagnosed with an approximate date diagnosed: _____

_____

_____

List any current health conditions you are being treated for: _____

_____

List any medications you are currently taking and what for (If you have a list, we can make a copy): _____

_____

_____

_____

List any vitamins you are currently taking: _____

_____

List any surgeries you have had with an approximate date: _____

_____

_____

List any prosthesis you may have (specify side):_____

List any recent falls or accidents you have had: _____

_____

List major health problems of immediate relatives: _____

_____

List hobbies/activities you like to do: _____

How many cigarettes do you smoke a day? _____/ day

How much alcohol do you drink per week? _____/week

How many cups of coffee/tea do you drink per day? _____/day

Do you use recreational drugs? Yes / No List: _____

REVIEW OF SYSTEMS

Are you currently experiencing any of these symptoms? (Circle all the apply)

Many of the following conditions respond to Chiropractic treatment.

General:
- Recent Weight Change
- Fever
- Fatigue

Musculoskeletal:
- Low Back Pain
- Mid Back Pain
- Neck Pain
- Arm Problems
- Leg Problems
- Painful Joints
- Stiff/Swollen/Sore Joints
- Weak Muscles or Joints
- Muscle Spasms/Cramps
- Broken Bones

Neurological:
- Numbness or tingling sensations
- Loss of Feeling
- Dizziness or light headed
- Frequent/Recurrent Headaches
- Convulsions or seizures
- Tremors
- Stroke

Mind/Stress:
- Nervousness
- Depression
- Sleep Problems
- Memory Loss or Confusion

Genitourinary:
- Sexual Difficulty
- Kidney Stones
- Burning/Painful Urination

Gastrointestinal:
- Loss of Appetite
- Blood in Stool
- Change in Bowel Movements
- Painful Bowel Movements
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation

Cardiovascular & Heart:
- Chest Pains
- Rapid or Heartbeat changes
- Blood Pressure Problems
- Swelling in Hands, Ankles, Feet
- Heart Problems

Respiratory:
- Difficulty Breathing
- Persistent Cough
- Coughing Blood
- Asthma or Wheezing
- Lung Problems

Eyes and Vision:
- Wear contacts/glasses
- Blurred or double vision
- Glaucoma
- Eye disease or injury

Ears, Nose and Throat:
- Swollen throat or voice change
- Swollen glands in neck
- Ringing in the ears
- Ache/Ringing/Drainage
- Sinus / Allergy problems
- Nose Bleeds
- Hearing Loss

Immune, Hematologic, Lymphatic:
- Thyroid problems
- Diabetes
- Excessive Thirst or urination
- Cold Extremities
- Heat or Cold intolerance
- Hormone problem
- Swollen Glands
- Anemia
- Easily Bruise or Bleed
- Immune system disorder

Skin and Breasts:
- Rash or Itching
- Change in Skin Color
- Change of appearance of a mole
- Breast Pain
- Breast Lump
- Breast Discharge

Women Only:

Are you pregnant?
- Yes - Due Date / /
- No - Last Menstrual Period / /
- Infertility
- Painful or Irregular periods
- Number of Pregnancies _____
- Change in Urination
- Frequent Urination
- Blood in Urine
- Incontinence or Bed Wetting

Any Other? _____

HEALTH GOALS

In order to help us better serve you, please choose from one of the following options.

_____I have a condition or symptom I would like help with.

_____I have a condition or symptom I would like help with and I'd be interested in learning how to keep it from coming back.

_____I have a condition or symptom I would like help with and I'd be interested in learning how to keep it from coming back. I'd also be interested in learning how Chiropractic care will help with my overall health.

What do you hope to do more of, or better, as your health returns? _____

_____

_____

_____

I, _____, hereby certify the information given on the 4 pages of this form is accurate to the best of my knowledge.

_____ _____

Patient or Guardian Signature Date