

# Chiropractic Case History

Name \_\_\_\_\_ Sex M F Date \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Referred by \_\_\_\_\_ Social Security \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Have you ever received Chiropractic Care? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_

## 1. Primary reasons for seeking chiropractic care:

Primary reason: \_\_\_\_\_  
Secondary reason: \_\_\_\_\_  
Other reasons: \_\_\_\_\_

## 2. Chief Complaint:

Location of Complaint: \_\_\_\_\_  
What was the initial cause of this complaint? \_\_\_\_\_  
When did this complaint begin? \_\_\_\_\_  
Are you presently under a doctor's care for this complaint? Y/N Doctors name: \_\_\_\_\_  
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 other areas of your body? Y/N Where? \_\_\_\_\_  
Do you have any numbness or tingling in your body? Where? \_\_\_\_\_  
Grade Intensity/Severity (0 No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (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? \_\_\_\_\_  
Does this complaint interfere with: work, home life, activities or sleep? Y/N \_\_\_\_\_

## 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: \_\_\_\_\_  
Condition/s you are taking medications for: \_\_\_\_\_  
F. Surgeries and dates: \_\_\_\_\_  
G. Pregnancies, Date of Delivery & Outcomes \_\_\_\_\_  
H. Date of the beginning of your last menstrual period? \_\_\_\_\_ Any menstrual problems? \_\_\_\_\_

## 5. Family Health History:

Associated health problems of relatives: \_\_\_\_\_  
Deaths in immediate family: \_\_\_\_\_  
Cause of parents or siblings death & age at death \_\_\_\_\_

## 6. Social and Occupational History:

A. Level of Education: \_\_\_\_\_  
B. Job description: \_\_\_\_\_  
C. Recreational activities: \_\_\_\_\_  
D. Do you take vitamins or supplements? Type and how often. \_\_\_\_\_  
E. Smoking and alcohol use. How often. \_\_\_\_\_

On a scale of 1 – 10. How committed are you to resolving this complaint? \_\_\_\_  
Are there any other health concerns you would like to address? \_\_\_\_\_

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 to provide me/child with chiropractic care, in accordance with this state's statutes.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_