Case History

Name_____ **Sex** M F **Date**_____

Address_____ **State**_____ **Zip**_____

C.Phone (_____) _____ **W.Phone**_____ **Date of Birth**_____ **Age**_____

Referred by_____ **Email**_____

Occupation_____ **Employer** _____

Have you ever received Chiropractic/Acupuncture Care? Yes No **If yes, when?**_____

1. Purpose of visit: Chiropractic | Acupuncture | Nutrition

Circle one/or all that applie(s):

Injury Pain in lower back Pain in upper back Joint Pain Headache Other

Chief complaint:_____

Secondary Reason:_____

Grade Severity (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Please circle the Quality of the complaint/pain:

dull aching sharp shooting burning deep nagging other

Does this complaint/pain radiate or travel (shoot) to any areas of your body? _____ **Where?**_____

Do you have any numbness/ tingling in your body? _____ **Where?**_____

How frequent is complaint present, how long does it last?_____

Does anything aggravate the complaint?_____

Does anything make the complaint better?_____

2. Previous treatment, medications, surgery, or care you've sought for your complaint your complaint:

_____

_____

3. Past Healthy History

A. **Previous illness/trauma/injury you've had in your life:**_____

_____

Have you ever broken any bones?_____ Which?_____

B. Medications/ Supplements

Medication or Supplement	Reason for taking

Medication or Supplement Continued:

_____ _____ _____

_____ _____ _____

D. Surgeries

Date Type of Surgery

_____ _____

_____ _____

_____ _____

E. Females / Pregnancies and outcomes:

Date of Delivery Outcome

_____ _____

_____ _____

_____ _____

F. Family Health History:

Associated health problems of relatives:_____

1. Recreational activities/exercise:_____
2. Lifestyle (hobbies, alcohol, tobacco and drug use, diet):_____
3. Daily water consumption:_____

G. Overall Diet:

How would you rate your overall diet? GOOD FAIR POOR

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 with care, in accordance with this state's statutes.

Signature of guardian_____ Date_____

Doctor's signature_____ Date_____

Notes: