**Patient Case History**

Name_____Date_____
Address_____State_____Zip_____
H. Phone (_____)_____ W. Phone_____Date of Birth_____Age_____
Referred by_____
Occupation_____Employer_____
Marital Status S M D W Spouse Name_____Number of Children/Ages_____
Have you ever received Chiropractic Care? Yes No If Yes, whom? _____How Long?_____
Will you be using insurance? Yes No. Ins. Company. _____Please allow us to photocopy card

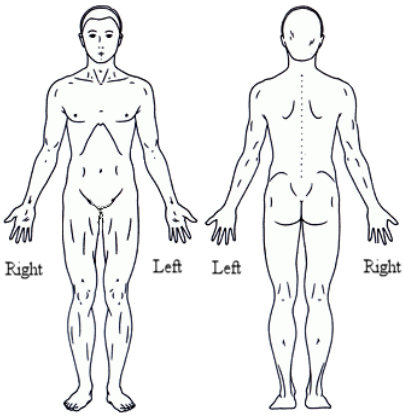
| Please circle for each of the following: | | Patient Comment If answer is Yes | Chiropractor's Comments |
|---|---|---|---|
| **1. Regarding your Birth Process:** | | | |
| Was the delivery long/difficult? | Y N | _____ | _____ |
| Forceps or extraction used? | Y N | _____ | _____ |
| Cesarean/ C-Section? | Y N | _____ | _____ |
| Circle: Home or Hospital birth? | | | |
| **2. Growth and Development/ Childhood:** | | | |
| Childhood illnesses? | Y N | _____ | _____ |
| Ear infections/ Colic/ Asthma? | Y N | _____ | _____ |
| Attention Deficit Disorder? | Y N | _____ | _____ |
| Antibiotics? | Y N | _____ | _____ |
| Auto accidents? | Y N | _____ | _____ |
| Did you ever break any bones? | Y N | _____ | _____ |
| **3. Current Health Habits:** | | | |
| Did/do you smoke? | Y N | _____ | _____ |
| Did/do you drink alcohol? | Y N | _____ | _____ |
| Diet, do you eat healthy foods? | Y N | _____ | _____ |
| Have you been in accidents/trauma? | Y N | _____ | _____ |
| Exercise regularly? | Y N | _____ | _____ |
| Hobbies/Sports injuries? | Y N | _____ | _____ |
| Do you sleep well, hours of sleep? | Y N | _____ | _____ |
| Sleeping posture? O side O stomach O back | | _____ | _____ |

**Symptoms and Present State of Health**

Present Complaint/Reason for Seeking Care in this Office:
Major_____
Pain or Problem started on_____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness or tingling in any area of your body? Where?_____
Since it began, is it: O Same O Better O Worst
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day?_____
Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
Other Doctors seen for this condition_____
Any home remedies? _____

Doctor's Notes

Please Circle where you are at:
(No Comp./Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Poss. Comp./Pain)
Using the symbols below, mark on the pictures where you feel pain.




| | |
|---|---|
| Numbness | = = = |
| Dull Ache | OOO |
| Burning | XXX |
| Sharp/Stabbing | / / / |
| Pins, Needles | + + + |
| Other _____ | ^ ^ ^ |

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

| | | |
|---|---|---|
| O Headaches | O Pain in Hands or Arms | O Chest Pains |
| O Neck Pain | O Numbness in Hands or Arms | O Heart Attack |
| O Sleeping Problems | O Pain in Legs or Feet | O High Blood Pressure |
| O Low Back Pain | O Numbness in Legs or Feet | O Stroke |
| O Nervousness | O Fatigue | O Cancer |
| O Tension | O Depression | O Painful Urination |
| O Irritability | O Lights Bother Eyes | O Diabetes |
| O Dizziness | O Loss of Memory | O Diarrhea |
| O Pain Between Shoulders | O Shoulder Pain | O Constipation |
| O Neck Stiff | O Sinus | O Stomach Upset |
| O Joint Swelling | O Shortness of Breath | O Heartburn/Reflux |
| O Fever | O Asthma | O Weight Loss |
| O Loss of Balance | O Allergies | O Loss of Smell or Taste |
| O Ringing in Ears | O Cold Hands | O Menstrual Cramps |
| O Jaw/TMJ Problems | O Cold Feet | O Menopause |

Are you under medical care for any condition?_____
What Medications are you taking?_____How long?_____
Have you had surgery?_____ What?_____ When?_____
What, if any side effects have you experienced from the drugs and surgery?_____
Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?___

**Is there a family History of:**

| | Heart Disease | Arthritis | Cancer | Diabetes | Other_____ |
|---|---|---|---|---|---|
| Father's side | O | O | O | O | O |
| Mother's side | O | O | O | O | O |

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____