Confidential Case History

Today's Date: _____

Name: _____ SS#:_____

Home#: ( )_____ Cell#: ( )_____ Work#: ( )_____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Birth date: _____ Age: ____ Sex: M F

Occupation: _____ Employer: _____

Employer's Address: _____ Yrs Employed: _____

Marital Status: S M D W Spouse's Name: _____ Spouse's Birth date: _____

Primary Care Physician: _____ PCP Clinic: _____

How many children: _____ How did you hear about our office? _____

MAIN COMPLAINT

1. Why are you here today? Be specific with location: _____
2. When and how did it start? _____
3. Work-related injury? **Y N** Auto accident? **Y N** Injury at home? **Y N** Injury elsewhere? **Y N**
4. Did it begin gradually or suddenly? _____
5. Has your problem been getting better, worse or about the same? _____
6. What makes your symptoms better? _____
7. What makes your symptoms worse? _____
8. Describe your pain: dull sharp burning numbness sore stiff tight achy Other: _____
9. Does your pain radiate to another part of your body? **Y N** Where? _____
10. How would you describe the pain intensity? mild moderate severe
11. Does your pain come and go or is it constant? come & go constant
12. Have you tried home remedies? **Y N** What? _____
13. List doctors seen and tests done for your condition: _____
14. Have you had anything like this before? **Y N** Describe: _____
15. Have there been any other changes in any body function? **Y N** Describe: _____
16. Has your condition affected your daily in anyway? **Y N** Describe: _____
17. Have you been unable to work as a result of your current problem? **Y N**
18. Do you have any other problems you would like the doctor to evaluate? **Y N** Describe: _____

CONTINUED ON REVERSE SIDE

PAST HISTORY

1. Have you ever been to a chiropractor before? **Y** **N** Whom? _____
2. List any medications you are taking: _____
3. List any surgeries and when you had them: _____
4. Have you been diagnosed with any other conditions? **Y** **N** Describe: _____
5. Have you had any broken bones? **Y** **N** List them: _____
6. Have you ever had any past significant auto accidents, work injuries or falls? **Y** **N** Describe:_____

   _____
7. Do you have any allergies? **Y** **N** Describe: _____
8. Do any diseases run in your family? **Y** **N** Describe: _____
9. Do you smoke, drink alcohol or use recreational drugs? **Y** **N** smoke alcohol recreational drugs

Please circle all present symptoms

HEAD:
- Headache
  - Sinus (allergy)
  - Entire head
  - Back of head
  - Forehead
  - Temples
  - Migraine
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bother eyes
- Blurred vision
- Loss of vision
- Loss of taste
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Bussing in ears

NECK:
- Pain in neck
- Neck pain with movement
  - Forward
  - Backward
  - Turn to left
  - Turn to right
  - Bend to left
  - Bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

MID-BACK:
- Mid-back pain
- Location_____
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

CHEST:
- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Irregular heartbeat

ABDOMEN:
- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:
- Low back pain
- Low back pain worse when:
  - Working
  - Stooping
  - Standing
  - Sitting
  - Bending
  - Coughing
  - Lying down (sleeping)
  - Walking
- Pain relieves when _____
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIPS, LEGS & FEET:
- Pain in buttocks (L – R)
- Pain in hip joint (L – R)
- Pain down leg (L – R)
- Pain down both legs
- Knee pain
  - Inside
  - Outside
- Leg cramps
- Cramps in feet (L – R)
- Pins & needles in legs (L – R)
- Numbness of leg (L – R)
- Numbness of feet (L – R)
- Numbness of toes

HIPS, LEGS & FEET (cont.)
- Feet feel cold
- Swollen ankles (L – R)
- Swollen feet (L – R)

WOMEN ONLY:
- Menstrual pain _____
- Cramping
- Irregularity
- Cycle _____ days
- Birth control _____ (type)
- Hysterectomy
- Genital cancer _____
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you are pregnant?

MEN ONLY:
- Urinary frequency
- Difficulty in starting
- Night urination
- Prostate pain/swelling

GENERAL:
- Nervousness
- Irritable
- Depression
- Fatigue
- Generally feel run-down
- Normal sleep _____
- Loss of sleep _____
- Loss of weight _____ lbs
- Gain of weight _____ lbs
- Coffee _____ cups per day
- Tea _____ cups per day
- Alcohol _____ drinks per week
- Cigarettes _____how many per day
- Other
- Diabetes
- Hypoglycemia
- Chills
- Fever
- Night sweats