PATIENT CASE HISTORY FILE

NAME _____ DATE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

TELEPHONE _____ CELL _____ ALT# _____

EMAIL ADDRESS _____ SOCIAL SECURITY NO. _____

AGE _____ BIRTH DATE _____ SEX _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMPLOYER'S PHONE _____

SPQUSE'S NAME _____

SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT _____ PHONE _____

RELATIONSHIP TO PATIENT _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

IS YOUR CONDITION DUE TO AN ACCIDENT? _____ WHEN? _____

IF YES, DID YOUR ACCIDENT OCCUR AT WORK? _____ WHEN? _____

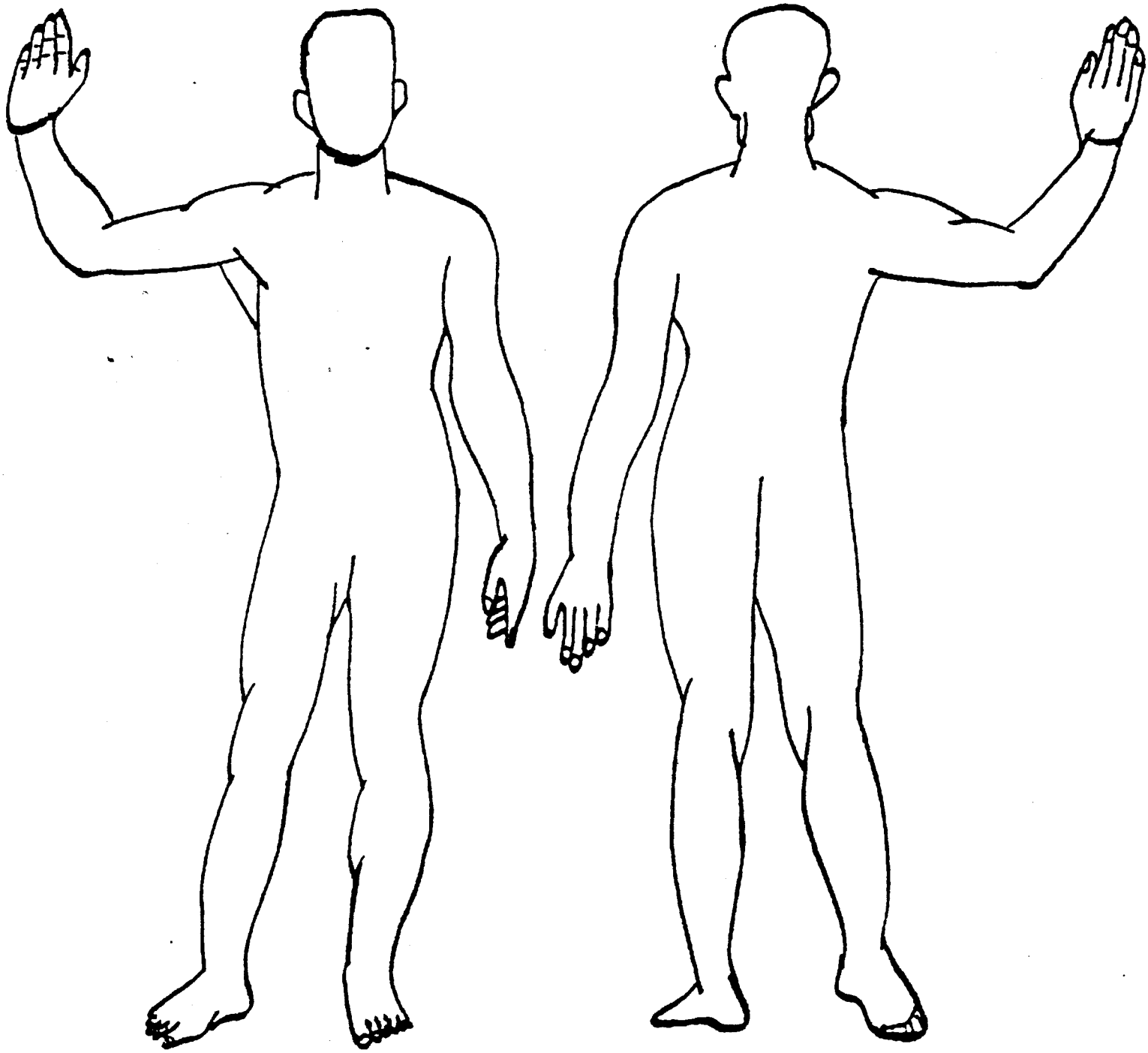
WERE YOU INVOLVED IN AN AUTOMOBILE ACCIDENT? _____ WHEN? _____

HAVE YOU USED A CHIROPRACTOR IN THE PAST? _____

PAIN DRAWING

NAME _____ DATE _____

Please Place X's on Areas of Complaints



FRONT **BACK**

SYMPTOMS

HEAD:
___ HEADACHE
  ___ ENTIRE HEAD
  ___ BACK OF HEAD
  ___ FOREHEAD
  ___ TEMPLES
  ___ MIGRAINE
___ HEAD FEELS HEAVY
___ LOSS OF MEMORY
___ LIGHT-HEADEDNESS
___ FAINTING
___ LIGHTS BOTHER EYES
___ LOSS OF SMELL
___ LOSS OF TASTE
___ LOSS OF BALANCE
___ DIZZINESS
___ LOSS OF HEARING
___ PAIN IN EARS
___ RINGING IN EARS
___ BUZZING IN EARS

NECK:
___ PAIN IN NECK
___ NECK PAIN WITH MOVEMENT
___ STIFF NECK
___ MUSCLE SPASMS IN NECK
___ GRINDING SOUNDS IN NECK
___ GRATING SOUNDS IN NECK
___ POPPING SOUNDS IN NECK
___ ARTHRITIS IN NECK

SHOULDERS:
___ PAIN IN SHOULDERS
___ PAIN ACROSS SHOULDERS
___ BURSITIS (R - L)
___ ARTHRITIS (R - L)
___ CANNOT RAISE ARMS
  ___ ABOVE SHOULDER LEVEL
  ___ OVER HEAD
___ TENSION IN SHOULDERS
___ PINCHED NERVE IN SHOULDERS (R - L)
___ MUSCLE SPASMS IN SHOULDERS (R - L)

ARMS:
___ PAIN IN UPPER ARM
___ PAIN IN FOREARM
___ PAIN IN HANDS
___ PAIN IN FINGERS
___ PINCHED NERVE IN ARM
___ PINCHED NERVE IN FINGERS
___ SENSATION OF PINS & NEEDLES IN ARMS
___ SENSATION OF PINS & NEEDLES IN FINGERS
___ FINGERS GO TO SLEEP
___ COLD HANDS
___ SWOLLEN JOINTS IN FINGERS
___ SORE JOINTS IN FINGERS
___ ARTHRITIS
___ LOSS OF GRIP STRENGTH

MID-BACK:
___ MID-BACK PAIN
___ PAIN BETWEEN SHOULDER BLADES
___ SHARP STABBING PAIN
___ MUSCLE SPASMS

CHEST:
___ CHEST PAIN
___ SHORTNESS OF BREATH
___ PAIN AROUND RIBS

ABDOMEN:
___ NERVOUS STOMACH
___ NAUSEA
___ GAS
___ CONSTIPATION
___ DIARRHEA

LOW BACK:
___ LOW BACK PAIN
___ LOW BACK PAIN IS WORSE WHEN
  ___ WORKING
  ___ LIFTING
  ___ STOOPING
  ___ STANDING
  ___ SITTING
  ___ BENDING
  ___ COUGHING
  ___ GETTING UP
___ PINCHED NERVE IN LOW BACK
___ SLIPPED DISK
___ LOW BACK FEELS OUT OF PLACE
___ MUSCLE SPASMS
___ ARTHRITIS

HIPS, LEGS, & FEET:
___ PAIN IN HIP JOINT (R - L)
___ PAIN DOWN LEG (R - L)
___ KNEE PAIN (R - L)
___ LEG CRAMPS (R - L)
___ PINS & NEEDLES IN LEG (R - L)
___ NUMBNESS OF LEG (R - L)
___ NUMBNESS OF FEET (R - L)
___ NUMBNESS OF TOES
___ COLD FEET
___ CRAMPS IN FEET (R - L)
___ SWOLLEN ANKLES (R - L)
___ SWOLLEN FEET (R - L)
___ PAINFUL JOINTS IN TOE
___ PAIN IN BUTTOCKS (R - L)

WOMEN ONLY:
___ MENSTRUAL PAIN
___ CRAMPING
___ IRREGULARITY

GENERAL:
___ IRRITABLE
___ DEPRESSED
___ FATIGUE
___ GENERALLY FEEL RUN-DOWN
___ LOSS OF SLEEP
___ LOSS OF WEIGHT
___ NERVOUSNESS

DRUG ALLERGIES

OTHER ALLERGIES

CURRENT MEDICATIONS Are you being treated for any disease now? What medications do you take? (Please give dose)

FAMILY HISTORY

Please ✓ Where applicable

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						

HOSPITALIZATION OR SURGERY

Reason: _____ Date _____

Reason _____ Date _____

WOMEN ONLY - Pregnant? ☐ YES ☐ NO

Planning Pregnancy? ☐ Yes ☐ No

PAST MEDICAL HISTORY Mark only those which apply.

☐ Headache
☐ Shortness of Breath
☐ Surgical Implants
☐ Heart Palpitations
☐ Heart Murmur
☐ Chest Pains
☐ Dizziness/Fainting
☐ Peripheral Vascular Disease
☐ Allergies/Hay Fever
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Ulcer
☐ GI Disorder
☐ Gall Bladder Disease
☐ Prostate Disease
☐ Bowel Irregularity
☐ Sexual Menstrual Dysfunction
☐ Venereal Disease
☐ Frequent Infections
☐ Hepatitis
☐ Anemia
☐ Arthritis
☐ Nervousness
☐ Depression
☐ Gout
☐ HIV POS
☐ Chronic Rashes
☐ Rheumatic Fever
☐ Mumps
☐ Measles
☐ Rubella
☐ Polio
☐ Diptheria
☐ Tetanus
☐ Sinusitis
☐ Other

SOCIAL HISTORY

☐ Tobacco
☐ Exercise Routine
☐ Alcohol - Type/Amount
☐ Diet - Salt Intake
☐ Caffeine
☐ Sleep Pattern

DESCRIBE WORK ACTIVITIES

DOCTOR'S ADDITIONAL INFORMATION / COMMENTS