

CASE HISTORY

Name _____ Age _____ Date _____
Address _____ City _____ Post Code _____
Phone (Home) _____ (Mobile) _____
Email _____
Date of Birth _____ Sex: M F Marital Status: S M D W
Occupation _____ Employer _____

HEALTH REPORT:

Reason for seeking care: _____

List any other doctors seen for this: _____

List any diagnosis and type of treatment: _____

Have you had similar injuries before? Yes No

If yes, explain: _____

Have you received chiropractic treatment previously? Yes No

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, explain: _____

Are you currently taking medication? Yes No

List medications and what condition they are for: _____

List any accidents, surgeries and traumas and the approximate dates: _____

Family History of any disease or illness. _____

Do you smoke? Yes No Alcohol? Yes No Daily _____ Weekly _____ Social Occasions _____

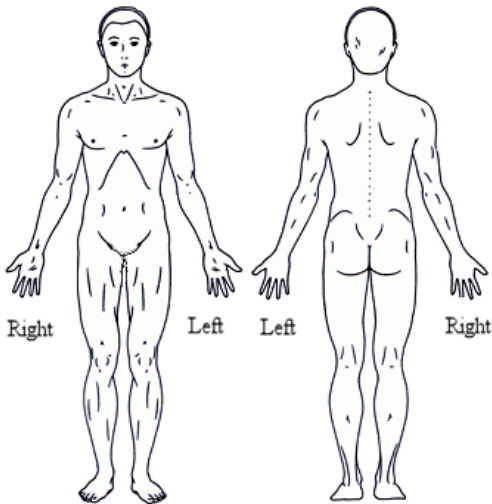
Exercise: Type and frequency _____

Do you take Vitamins/Supplements - If yes, please list: _____

Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.



- Numbness ===
- Dull Ache OOO
- Burning XXX
- Sharp/Stabbing ///
- Pins, Needles +++

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? If yes, when _____

Is this condition interfering with:

Work _____ Sleep _____ Routine _____ Other _____

Is this condition progressively getting worse? _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N

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 _____