



Chiropractic Case History

Name _____ Sex M F Date _____
Address _____ State _____ Zip _____
Day Phone(____) _____ Evening Phone(____) _____ D. o. B. _____ Age _____
E-mail Address _____ Referred by _____
S.S. # _____ Occupation _____ Employer _____
Single Partnered Married Spouse/Partner Name _____ Employer _____
Name of Primary Care Doctor _____ Phone _____
Address _____ Permission to contact him/her regarding treatment yes no
Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. Reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other

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

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

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

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

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
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E. Surgeries:

Date	Type of Surgery
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F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
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What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Family history of neck and back trouble: _____

Children (ages and physical activities) _____

6. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

7. Insurance Information

Insurance Company: _____

Type: _____ ID# _____ Group# _____

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 of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature (Parent or Guardian if minor) _____

Date _____

Doctor's Signature _____

Date _____