



Patient #

### CONFIDENTIAL CHIROPRACTIC CASE HISTORY

Date \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Gender M F Marital Status: M S S/O Spouse-S/O Name \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

How did you hear about us / Referred by \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No If yes, when? \_\_\_\_\_

1. Primary reasons for seeking chiropractic care: \_\_\_\_\_

2. Chief Complaint: \_\_\_\_\_

Complaint began when and how? \_\_\_\_\_

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

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

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

**Past Health History:**

A. Recent illnesses you've had in your life: \_\_\_\_\_

B. Recent injury or trauma: \_\_\_\_\_

Have you ever broken any bones? Which? \_\_\_\_\_

C. Allergies: \_\_\_\_\_

D. Medications: \_\_\_\_\_

E. Surgeries: Date \_\_\_\_\_ Type of Surgery \_\_\_\_\_

F. Recent X-Rays: Date \_\_\_\_\_

G. Females/ Pregnancies and outcomes: \_\_\_\_\_

Currently Pregnant: Y N Currently Nursing: Y N Date of your last menstrual period? \_\_\_\_\_

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.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_