



CONFIDENTIAL CASE HISTORY

Please complete this questionnaire. Your answers will help us determine how our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Name: Mr. Mrs. Ms. Miss Dr. _____
Address: _____ City: _____
State/Zip code: _____ Date of Birth: m ___ d ___ yr ___ Marital Status: Married Single
Home Telephone: _____ Business Telephone: _____
Cellular Telephone: _____ e-mail address: _____
Employer: _____ Address: _____
Occupation: _____ Hobbies: _____
Spouse's Name: _____ Children's Names: _____
Children's Names: _____ Children's Names: _____
How did you hear about our office? _____

HEALTH INFORMATION

Have you ever been to a chiropractor before? Yes No
If so, what was the reason? _____
Have you had previous healthcare for this problem? Yes No
If yes, where? _____ When? _____
Have you ever had physical therapy before? Yes No Are you interested in having physical therapy? Yes No
Have you ever had massage therapy before? Yes No Are you interested in having massage therapy? Yes No

REASON FOR CONSULTING OUR OFFICE

I have a specific problem and require help only with this problem.
 After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.
 After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
 I have no symptoms and feel well. I am interested in strategies to help me to continue to feel well, or even better.
What is/are your major complaint(s)? _____
How long have you had this condition? _____
Have you had this or similar conditions in the past? Yes No If yes, when? _____
What activities aggravate your condition? _____
What makes it better? _____
Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your Work Sleep Daily Routine Other _____

How long has it been since you really felt well? _____

List surgical operations and/or major injuries: _____

List any prescription drugs, over the counter drugs, vitamins and natural supplements you currently take: _____

Are you wearing Heel Lifts Sole Lifts Inner soles Arch support Orthotics

Have you been in an auto accident: Never Recently Past year Past 5 years or more

Describe the accident: _____

Have you had any other personal injury or accident: Never Recently Past year Past 5 years or more

Describe: _____

Date of most recent physical examination: _____

PLEASE MARK THE AREAS OF PAIN AND/OR DISCOMFORT ON THE FIGURES BELOW:

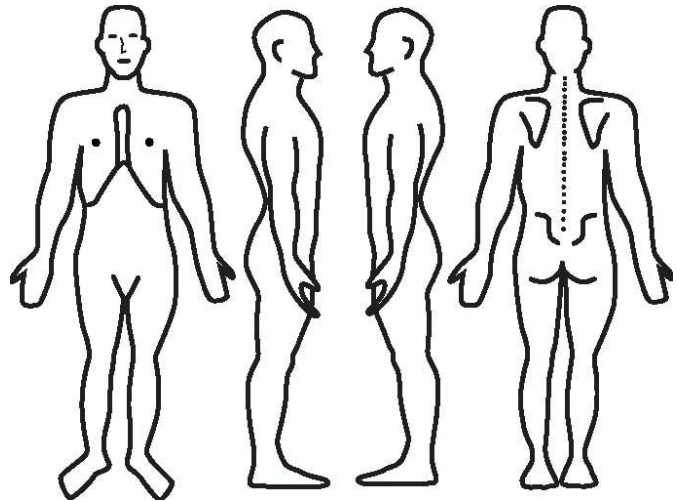
Mark an **X** on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

- Sharp
- Dull
- Throbbing
- Numbness
- Aching
- Shooting
- Burning
- Tingling
- Cramps
- Stiffness
- Swelling
- Other

How often do you have this pain? _____



Front Right Left Back

Are you affected by any of the following? Please check: O = Occasionally F = Frequently C = Constantly

	O F C		O F C		O F C
Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heartburn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Backache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Migraines	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Neck pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Digestive upset	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Females Only:	
Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Painful menstruation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sore throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Shoulder pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	PMS	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Foot pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Leg pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgement for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ Dated: _____