CONFIDENTIAL CASE HISTORY FILE

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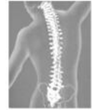
856-685-7691



Date: ______________________

Full Legal Name: ____ **Name you prefer:** ____________

Address: ____ **City/State/Zip:** ____________________

Phone (cell) ( ) ________________ **(work)** ( ) ________________ **SSN#** ______ - ______ - ______

Birth date: ____ / ____ / ____ **Age:** ______ **Sex:** ______ **Ht:** _____ **Wt:** _____ **Marital Status:** _____

Spouse's Name: __________________________ **# Children** _______ **Handedness:** (L) (R)

Emergency Contact: _________________________________ **Phone:** ( ) ________________________

Your Employer: ____

Employer's Address: ____ **City/State/Zip:** _____________

Job title: _________________________________

Referred by: __________________________

E-mail address: _________________________________

MEDICAL HISTORY: *(please be complete)*

List any surgeries (include dates & reason): ____

List any hospitalizations (include dates & reason): ____

List any auto accident injuries (include dates): ____

List any on the job injuries (include dates): ____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.)

____

List all current over-the-counter and prescription medications used (include reason used):

____

____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

____

Have you been under a physician's care in the past year? ☐ no ☐ yes (reason) ____________________

When was your last physical examination? ________________________________ **Dr:** ____________

Have you ever been under chiropractic care? ☐ no ☐ yes (describe) ____________________________

If female, is there a possibility that you are pregnant? ☐ no ☐ yes

Do you smoke/use tobacco? ☐ no ☐ yes **Exercise habits?** ☐ never ☐ occasional ☐ frequent

Check any of the following symptoms you have noticed: (■ = Previously, ☐ = Now)

■ ☐ Headaches	■ ☐ Low back pain	■ ☐ Sensitive to light or sound
■ ☐ Dizziness or light-headed	■ ☐ Leg/foot numbness/tingling	■ ☐ Visual or hearing disturbance
■ ☐ Jaw pain, clicking, or locking	■ ☐ Leg/foot fatigue/weakness	■ ☐ Memory loss/problems
■ ☐ Pain or difficulty swallowing	■ ☐ Leg pain with walking	■ ☐ Irritability or depression
■ ☐ Neck pain or stiffness	■ ☐ Abdominal pain	■ ☐ Fatigue or loss of energy
■ ☐ Shoulder pain	■ ☐ Nausea or vomiting	■ ☐ Fainting or convulsions
■ ☐ Mid back pain	■ ☐ Diarrhea or constipation	■ ☐ Trouble with balance or coordination
■ ☐ Chest pain or cough	■ ☐ Blood in urine or stool	■ ☐ Sleep disturbances/problems
■ ☐ Pain/trouble breathing	■ ☐ Difficulty or pain w/ urination	■ ☐ Rashes (face, body, limbs)
■ ☐ Arm/hand numbness/tingling	■ ☐ Difficulty with sexual function	■ ☐ Joint pain or swelling
■ ☐ Arm/hand fatigue/weakness	■ ☐ Abnormal menstrual periods	■ ☐ Pain with exertion (activity, climbing stairs, etc.)

HAVEYOU HAD *ANY* OF THE FOLLOWING:

RECENT:

☐ Pain worse at night
☐ Constant pain
☐ Unexplained weight loss
☐ Recent bacterial infection (30 days)
☐ Loss of bowel or bladder control
☐ Urinary discharge
☐ Recent surgery (30 days)

EVER:

☐ History of cancer
☐ History of IV drug use
☐ History of blood transfusion

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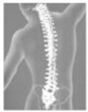


What is your primary complaint/problem?___________________________

Any other areas of concern:___________________________

When did your symptoms first begin (give date if possible)?___________________________

How did your symptoms first begin? ___________________________

Pain is: ☐ **Constant** ☐ **Intermittent** **Is your condition getting worse?**__________

What activities aggravate your condition?(list)___________________________

What activities lessen your symptoms? (list)___________________________

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. ___________________________
2. ___________________________
3. ___________________________

Have you had: ☐ **Xray** ☐ **MRI or CAT Scan** ☐ **EMG** ☐ **Bone Scan** ☐ **Blood Work**

Who is your family medical doctor: ___________________________

List all remedies tried for this problem:___________________________

Is your condition worse at certain times of the day or night?___________________________

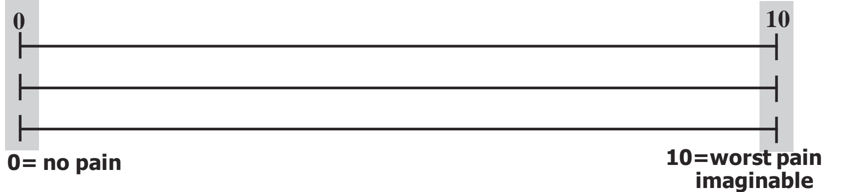
Does your condition interfere with: (yes/no) **work** _____ **sleep** _____ **normal daily routine** _____

Have you had symptoms like this before? ☐ **no** ☐ **yes (describe)**___________________________

Regarding your main complaint:

How bad is your pain?
(mark an "X" on all 3 scales)

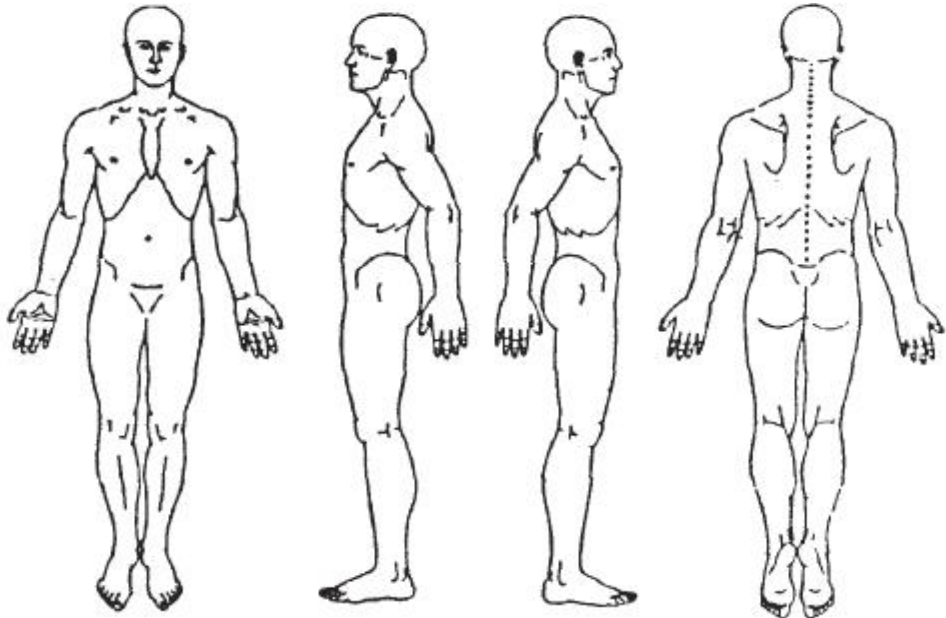
1. RIGHT NOW:
2.AVERAGE:
3.AT WORST:



Draw the area of your symptoms:

(mark on the figures and write the words to describe the feeling)

Examples: **ache/ sore**
sharp/stabbing
numb/tingle
shooting
stiff/tight
annoying/ burning



NOTICE TO NEW PATIENTS: Payment for chiropractic services rendered is due in *full* at the end of each visit. If for any reason this request cannot be met, other arrangements must be made as this is your responsibility. I **consent to treatment and** grant permission to the doctor to use the information in my medical record to assist in the clinical improvement process.
We respect and value your privacy.

Patient Signature:___________________________ **Date**__________________