# PEEKS CHIROPRACTIC PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Contact Preference: ☐ Home ☐ Work ☐ Cell ☐ Email

Employer: _____Occupation: _____

Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Widowed

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: ☐ Male ☐ Female

Referred by: _____ Previous Chiropractor: _____

Emergency Contact: _____ Phone #: _____-_____-_____

Height: _____ Weight: _____

**List <u>ALL</u> <u>Past Medical History</u> conditions:**

☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression ☐ Diabetes ☐ Dizziness

☐ Elbow Pain ☐ Epilepsy ☐ Fainting ☐ Fatigue ☐ Foot Pain ☐ Headaches ☐ High Blood Pressure ☐ Hip Pain

☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Low Back Pain ☐ Menstrual Problems ☐ Mid-Back Pain

☐ Neck Pain ☐ Neurological Problems ☐ Shoulder Pain ☐ Spinal Cord Injury ☐ Sprain/Strain ☐ Stroke/Heart Attack

☐ Other: _____

**List any <u>Surgeries</u> and note year:**

☐ Back _____ ☐ Brain _____ ☐ Elbow _____ ☐ Foot _____ ☐ Hip_____ ☐ Knee_____

☐ Neck _____ ☐ Neurological _____ ☐ Shoulder_____ ☐ Wrist_____ ☐ Other: _____

**Do you nap/sleep on the couch?** ☐ No ☐ Yes

**Do you read in bed?** ☐ No ☐ Yes

**Have you had any auto or other incidents?** ☐ No ☐Yes

Describe and note year: _____

_____

**Have you had in the past year:** ☐Blood Test ☐Urine analysis ☐MRI ☐CT Scan ☐Ultrasound ☐ X-rays

Please note the reason for the tests _____

**<u>For Women Only</u>**

**Month of last period** _____ **Are you pregnant?** ☐ No ☐ Yes

**********<u>***LIST ONLY ONE COMPLAINT IN EACH SECTION***</u>**********

**What is your PRIMARY complaint? _____Date problem began? _____**

**How did this problem begin (falling, lifting, etc.)? _____**

**Have you had this condition in the past?** □ No □ Yes

**How is your condition changing?** □ Getting better □ Getting worse □ Not changing

**Please rate your pain (1= no pain and 10= excruciating pain)** □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**Describe the nature of your symptoms:** □ Burning □ Dull □ Numb □ Radiating Pain □ Sharp □ Shooting □ Soreness □ Spasm □ Stabbing □ Stiffness □ Throbbing □ Tightness □ Tingling □ Other: _____

**How often do you experience your symptoms?** □ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

**How do your symptoms affect your ability to perform daily activities such as working or driving? (1= no effect and 10= prevents any activities)** □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**What activities aggravate your condition (working, exercise, etc)? _____**

**Dr. Notes: _____**

_____

_____

**Do you have a SECONDARDY complaint? _____Date problem began? _____**

**How did this problem begin (falling, lifting, etc.)? _____**

**Have you had this condition in the past?** □ No □ Yes

**How is your condition changing?** □ Getting better □ Getting worse □ Not changing

**Please rate your pain (1= no pain and 10= excruciating pain)** □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**Describe the nature of your symptoms:** □ Burning □ Dull □ Numb □ Radiating Pain □ Sharp □ Shooting □ Soreness □ Spasm □ Stabbing □ Stiffness □ Throbbing □ Tightness □ Tingling □ Other: _____

**How often do you experience your symptoms?** □ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

**How do your symptoms affect your ability to perform daily activities such as working or driving? (1= no effect and 10= prevents any activities)** □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**What activities aggravate your condition (working, exercise, etc)? _____**

**Dr. Notes: _____**

_____

_____

**If you have any other complaints use additional sheets.**

**The information given above is accurate and true.**

**Patient's signature _____ Date_____**