Case History

Patient Name: _____ Date: _____

Symptoms

Primary Complaint _____Problem Started On _____

Pains are: □ Sharp □ Dull □ Throbbing □ Aching □ Numbness □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other_____

Rate the severity of your pain (1-mild pain or discomfort, to 10-severe pain): 1 2 3 4 5 6 7 8 9 10

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Is the pain constant or does it come and go? _____ How often do you have it? _____

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are difficult to perform:

□ Sitting □ Standing □ Walking □ Bending □ Lying Down □ Other _____

What activities lessen your condition/ pain? _____

What treatment have you already received for this condition? □ Medications □ Physical Therapy
□ Surgery □ Chiropractic □ No ne □ Other _____

Names of Doctors who treated you for this condition _____

Rate the priority level of your desire to *correct* this problem (1-low, 10-high): 1 2 3 4 5 6 7 8 9 10

Type of accident? □ Auto □ Work □ Home □ Other _____ Have you reported it? □ Yes □ No

Other Symptoms

□ Headaches	□ Pins & Needles in Legs	□ Loss of Smell
□ Neck Pain	□ Pins & Needles in Arms	□ Loss of Taste
□ Upper Back Pain	□ Numbness in Fingers	□ Diarrhea/Constipation
□ Mid Back Pain	□ Numbness in Toes	□ Cold Feet
□ Low Back Pain	□ Shortness of Breath	□ Cold Hands
□ Hip Pain	□ Fatigue	□ Stomach Upset
□ Leg Pain	□ Depression	□ Loss of Balance
□ Shoulder Pain	□ Ears Ringing/Buzzing	□ Loss of Memory
□ Chest Pain	□ Light Bothers Eyes	□ Irritability
□ Dizziness/Fainting	□ Nervousness	□ Tension

(Women) Are you Pregnant? □ Yes □ No Nursing? □ Yes □ No Taking Birth Control? □ Yes □ No

Daily Habits

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy
Work Habits: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor
Sleep Position: ☐ Side ☐ Stomach ☐ Back

Do You Smoke? ☐ Yes ☐ No ☐ Packs/ Day _____
Do You Drink Alcohol? ☐ Yes ☐ No ☐ Drinks/ Week _____
Coffee/ Caffeine Drinks? ☐ Yes ☐ No ☐ Cups/ Day _____
Do You Have High Stress? ☐ Yes ☐ No ☐ Reason _____

What Vitamins/ Nutritional Supplements do you take? _____
_____
What Medications are you taking? _____
_____

Health History

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Auto Accidents		
Other		

Mark only those conditions which are applicable:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other_____

☐ Glaucoma ☐ Pinched Nerve _____

Is there a family history of	Heart Disease	Arthritis	Cancer	Diabetes
Mother's Side	☐	☐	☐	☐
Father's Side	☐	☐	☐	☐

When you were a child:

Did you have a difficult birth process? □ Yes □ No □ Caesarean □ Breach □ Forceps

Did you fall or have other traumas? □ Yes □ No

Were you shaken, yanked or abused? □Yes □ No

Have you been taught proper body movement and care? □ Yes □ No

My Health Attitude - Please mark which one applies to you

- ☐ **Treatment Only-** I only consult a doctor when I have an ache or a pain and discontinue treatment as soon as it is cleared up.
- ☐ **Prevention-** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.
- ☐ **Maintaining Health-** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- ☐ **Family Health-** I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____ Date _____