PATIENT CASE HISTORY **Patient Name:** ____

Is this Condition: • Insurance • Worker's Comp • Self-Pay (Cash) • Personal Injury/Auto • Other : ______________________

Describe Major Complaint: ____

When: ___/____/____ **Describe how this began**: ____

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*___________________________________

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: ____________________________________

Circle – Fil In – Circle any activities that affect your symptoms:

	(Circle if applies)	(Fill in if applies)	(Circle one if applies)
Activity (any):	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Activity (inactive)	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Bending:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Computer:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Drive/Travel	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Exercise:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Family Care:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Heat:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Ice:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
In/out car/chair:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Lifting:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Look over shoulder:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Lying down	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
OTC/Meds:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Overuse:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Personal Care:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Reach overhead:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Recreation:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Sitting:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Sleep/Rest:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Stairs:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Standing:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Stretching:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Walk:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Work:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever
Yard work:	PAIN or RELIEF	**-- Time before Pain Starts:** _____minutes/_____hours	(**If Pain what Level**): mild/ moderate/ sever/ very sever

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Surgery/ OTC/ Prescriptions/ Other:________________________
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: ____

Medication Allergies/ NONE: ________________________

____

Current Medications: ______________________________

____

Past Health History: (surgeries/ date/ type/ reason): _______

____

Major Injuries/ Traumas: __________________________

____

Family Health History: ______________________________

____

Deaths in Family (causes): __________________________

____

____

Social and Occupational History: ____________________

____

Habits: Cigarettes/ Alcohol/ Coffee/ Tea/ Rec. Drugs

REVIEW OF SYSTEMS

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- Recent Weight Change
- Fever
- Fatigue
- *None in this Category*

Musculoskeletal:
- Low Back Pain
- Mid Back Pain
- Neck Pain
- Arm Problems ________________
- Leg Problems ________________
- Painful Joints
- Stiff/Swollen Joints
- Sore/Weak Muscles or Joints
- Muscle Spasms/Cramps
- Broken Bones_________________
- Other: ______________________
- *None in this Category*

Neurological:
- Numbness or tingling sensations
- Loss of Feeling
- Dizziness or light headed
- Frequent or Recurrent Headaches
- Convulsions or seizures
- Tremors
- Stroke
- Have you ever had a head injury?
- Ever been in an auto accident?
- Other: ______________________
- *None in this Category*

Mind/Stress:
- Nervousness
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: ______________________
- *None in this Category*

Genitourinary:
- Sexual Difficulty
- Kidney Stones
- Burning/Painful Urination
- Change in force/strain w Urination
- Frequent Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Other: ______________________
- *None in this Category*

Gastrointestinal:
- Loss of Appetite
- Blood in Stool
- Change in Bowel Movements
- Painful Bowel Movements
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: ______________________
- *None in this Category*

Cardiovascular & Heart:
- Chest Pains
- Rapid or Heartbeat changes
- Blood Pressure Problems
- Swelling of Hands, Ankles, or Feet
- Heart Problems
- Other: ______________________
- *None in this Category*

Respiratory:
- Difficulty Breathing
- Persistent Cough
- Coughing Blood
- Asthma or Wheezing
- Lung Problems
- Other: _________________
- *None in this Category*

Eyes and Vision:
- Wear contacts/glasses
- Blurred or double vision
- Glaucoma
- Eye disease or injury
- Other: ______________________
- *None in this Category*

Ears, Nose and Throat:
- Bleeding gums / mouth sores
- Bad Breath or bad taste
- Dental Problems
- Swollen throat or voice change
- Swollen glands in neck
- Ringing in the ears
- Ear - Ache/Ringing/Drainage
- Sinus / Allergy problems
- Nose Bleeds
- Hearing Loss
- Other: ______________________
- *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- Thyroid problems
- Diabetes
- Excessive Thirst or urination
- Cold Extremities
- Heat or Cold intolerance
- Change in hat or glove size
- Dry skin
- Glandular or hormone problem
- Swollen Glands
- Anemia
- Easily Bruise or Bleed
- Phlebitis
- Transfusion
- Immune system disorder
- Other: ______________________
- *None in this Category*

Skin and Breasts:
- Rash or Itching
- Change in Skin Color
- Change in hair or nails
- Non-healing sores
- Change of appearance of a mole
- Breast Pain
- Breast Lump
- Breast Discharge
- Other: ______________________
- *None in this Category*

Women Only:

Are you pregnant?
- **Yes -** ***Due Date*** _____/____/____
- **No -** ***Last Menstrual Period*** ___/____/____

- Infertility
- Painful or Irregular periods
- Vaginal Discharge
- Other: ______________________
- *None in this Category*

Pregnancies with Outcome & Date:

____

____

____

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 to provide me with chiropractic & acupuncture care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature____Date____________________

Patient or Guardian Print: ____ Treating Doctor Signature______________________