BackSmarts Sports Medicine and Chiropractic

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Chiropractic Case History

Name__________________________________ Sex M F Date____________________
Adress_____________________________City_______________State______Zip_______
Phone(___)___________W. Phone(___)___________Date of Birth__________Age____
Email address____
Referred by_____________________Marital Satus______________________________
Occupation____________________________________Employer___________________
Have you ever received Chiropractic care? Yes No If yes when?_______________

Primary reason for seeking Chiropractic care:

Primary reason:____
Secondary reason:____
Other factors contributing to primary and secondary reasons:________________________
____
Chief complaint:____
Location of complaint:____
Complaint began when and how?____

Please circle the quality of the complaint/pain: Dull Aching Sharp Shooting Burning Throbbing Nagging Deep Other:____

Does the complaint/pain travel (shoot) to any areas of your body? Where?_____________
Do you have any numbness or tingling in your body? Where?______________________
Grade intensity/severity or pain: 0 1 2 3 4 5 6 7 8 9 10 (higher # greater pain)
How frequent is complaint present, how long does it last?__________________________
Does anything aggravate the pain?____
Does anything make complaint better?____

Previous interventions, treatments, medications, surgeries, or care you've sought for your complaint?:____
____
____

Past health history:

Previous illnesses you've had in your life:____
____
____

Previous injury or trauma:____
____

Have you ever broken any bones? Which?____
____

Allergies____

Medications: ___________________________________

Reason for taking: ___________________________________

Surgeries: ___________________________________

Type of Surgery: ___________________________________

Female pregnancies and outcomes: ___________________________________

Date of delivery: ___________________________________

What was the date of the beginning of your last menstrual period?____________________

Family health history:

Associated health problems of relatives:____

Deaths in immediate family: ___________________________________

Age of death: ___________________________________

Social and occupational history:

Job description:____
Work schedule:____
Recreational activities:____
Lifestyles (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____________

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 of Chiropractic to provide me with Chiropractic care, in accordance with the state's statutes.

Patient or guardian signature________________________________date_______________

Doctor's signature____date_______________