

### Chiropractic Case History

#### Patient Information

Full Name: \_\_\_\_\_ Sex: M F Date: \_\_\_\_\_  
*Last First*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Referred by: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Have you ever received Chiropractic care ? Y N If yes, when? \_\_\_\_\_

#### Reason for Seeking Chiropractic Care

Primary Reason: \_\_\_\_\_

Secondary Reason: \_\_\_\_\_

Other factors contributing to reasons for visit: \_\_\_\_\_

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? Y N Where? \_\_\_\_\_

Do you have numbness or tingling in your body? Y N Where? \_\_\_\_\_

Grade intensity/severity of pain (10 being greatest): 0 1 2 3 4 5 6 7 8 9 10

How frequent is the complaint and how long does it last? \_\_\_\_\_

Does anything aggravate the pain? \_\_\_\_\_

Does anything make it better? \_\_\_\_\_

Previous interventions, treatments, medications, surgeries, or care you have sought for this complaint: \_\_\_\_\_

**Past Health History**

Previous Illnesses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous injury or trauma: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you broken any bones? Y N Which? \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reasons for taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Type and date of surgery: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Female pregnancies and outcomes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of delivery: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Disclaimer and Signature**

*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: \_\_\_\_\_