CONFIDENTIAL CASE HISTORY FILE

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Date: _____

Full Legal Name: _____ **Name you prefer:** _____

Address: _____ **City/State/Zip** _____

Phone: (home) (____) _____ **(work)** (____) _____ **(cell)** (____) _____

Birth date: ____/____/____ **Age:**_____ **Sex:** _____ **Soc Sec #** _____

Marital Status S M W D Sep Spouse's Name: _____ **# Children** _____

Emerg. contact:_____**Relationship**_____**Phone:**(____) _____

Your Employer: _____ **Phone:** (____) _____

Employer's Address:_____ **City/State/Zip** _____

Job title: _____ **Supervisor Name:** _____

e-mail address: _____ **Referred by:** _____

MEDICAL HISTORY *(please be complete)*

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason):_____

List any auto accident injuries (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

_____

List all current over-the-counter and prescription medications used (include reason used):

_____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

_____

Have you been under a physician's care in the past year? ☐ **no** ☐ **yes (reason)** _____

When was your last physical examination? _____ **Dr:** _____

Have you ever been under chiropractic care? ☐**no** ☐**yes (describe)** _____

If female, is there a possibility that you are pregnant? ☐ **no** ☐ **yes**

Do you smoke/use tobacco? ☐ **no** ☐ **yes** **Exercise habits?** ☐**never** ☐**occasional** ☐ **frequent**

Check any of the following symptoms you have noticed: (■ = Previously, ☐ = Now)

■☐ Headaches	■☐ Low back pain	■☐ Sensitive to light or sound
■☐ Dizziness or light-headed	■☐ Leg/foot numbness/tingling	■☐ Visual or hearing disturbance
■☐ Jaw pain, clicking, or locking	■☐ Leg/foot fatigue/weakness	■☐ Memory loss/problems
■☐ Pain or difficulty swallowing	■☐ Leg pain with walking	■☐ Irritability or depression
■☐ Neck pain or stiffness	■☐ Abdominal pain	■☐ Fatigue or loss of energy
■☐ Shoulder pain	■☐ Nausea or vomiting	■☐ Fainting or convulsions
■☐ Mid back pain	■☐ Diarrhea or constipation	■☐ Trouble with balance or coordination
■☐ Chest pain or cough	■☐ Blood in urine or stool	■☐ Sleep disturbances/problems
■☐ Pain/trouble breathing	■☐ Difficulty or pain w/ urination	■☐ Rashes (face, body, limbs)
■☐ Arm/hand numbness/tingling	■☐ Difficulty with sexual function	■☐ Joint pain or swelling
■☐ Arm/hand fatigue/weakness	■☐ Abnormal menstrual periods	■☐ Pain with exertion (activity, climbing stairs, etc.)

HAVE YOU HAD *ANY* OF THE FOLLOWING:

NOW:

- ☐ Pain worse at night
- ☐ Constant pain
- ☐ Unexplained weight loss
- ☐ Recent bacterial infection (30 days)
- ☐ Loss of bowel or bladder control
- ☐ Urinary discharge
- ☐ Recent surgery (30 days)

EVER:

- ☐ History of cancer
- ☐ History of IV drug use
- ☐ History of blood transfusion

Information about your current condition/complaints

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What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: ☐ **Constant** ☐ **Intermittent** **Is your condition getting worse?** _____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. _____

2. _____

3. _____

Have you had: ☐ **Xray** ☐ **MRI or CAT Scan** ☐ **EMG** ☐ **Bone Scan** ☐ **Blood Work**

Who is your family medical doctor: _____

List all home remedies tried for this problem: _____

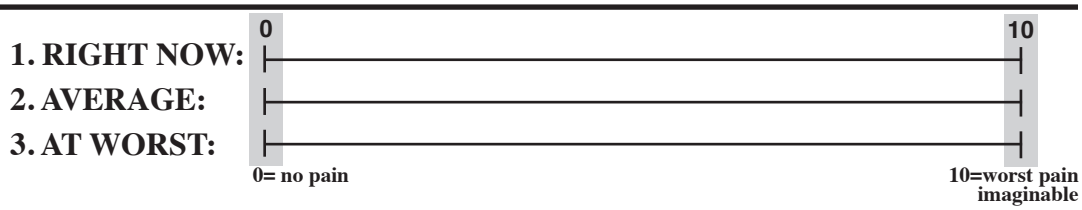
Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) **work** _____ **sleep** _____ **normal daily routine** _____

Have you had symptoms like this before? ☐ **no** ☐ **yes (describe)** _____

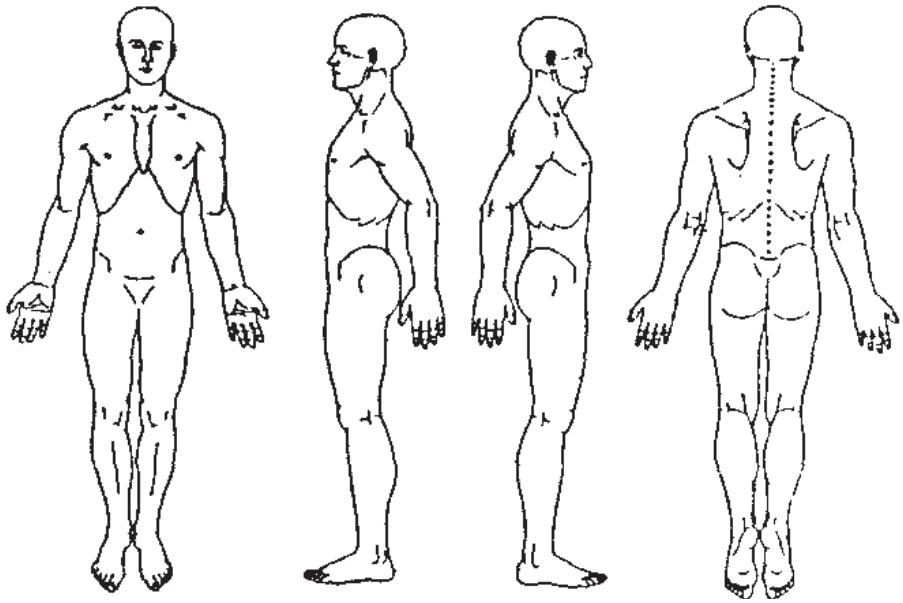
Regarding your main complaint:

How bad is your pain?
(make a slash on all 3 scales)



Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
✳ = sharp/stab
ooo = numb/tingle
⟶ = shooting
/ / / / = stiff/tight



Pt. History 3.1
#1.04 SCSI©

NOTICE TO NEW PATIENTS: **Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.**

Patient Signature: _____ **Date** _____