Patient Case History

Name _____ Date of Birth _____
Street _____ City _____ State _____ ZIP _____
Home Phone _____ Cell Phone _____ Cell Carrier _____
Email address (*office use only!*) _____ Referred by _____
Marital Status: Single / Married Spouse _____ Phone # _____
Emergency Contact _____ Relationship _____ Phone # _____
Your Occupation _____ Employer _____
Insurance Name _____
Insured Name _____ Relationship _____
Insured Birthdate _____

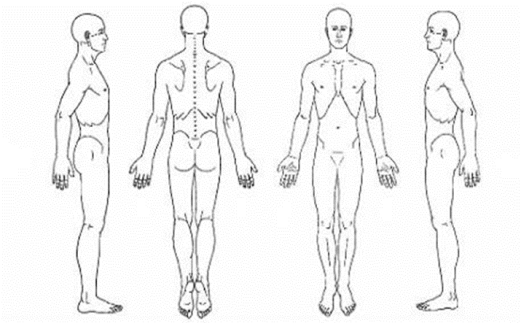
Please list your reason(s) for this visit or your condition(s) in order of importance	Date you first noticed	Using a scale in which "0" is no pain or symptoms and "10" is severe pain or symptoms, **circle** the number that best reflects your condition: none to severe	Please check the box below that best represents how **much of the time** you feel pain or note symptoms for the listed reason:
1.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
2.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
3.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
4.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%

For each of the reasons or conditions listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER		
	better	worse	better	worse	better	worse	better	worse	better	worse	(please describe on line below)
Reason 1	___	___	___	___	___	___	___	___	___	___	_____
Reason 2	___	___	___	___	___	___	___	___	___	___	_____
Reason 3	___	___	___	___	___	___	___	___	___	___	_____
Reason 4	___	___	___	___	___	___	___	___	___	___	_____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ sharp or stabbing
ooo pins and needles
vvv dull or aching
/// numbness



During what time of the day do you feel worse? _____
Do you sleep well? Yes / No What are your normal sleeping hours? _____ to _____

Medical History

Patient Name _____

Height _____ _ Weight _____Family Doctor _____ Phone _____

Medication list (attach list if necessary) _____

Supplements (attach list if necessary) _____

Surgeries (year) _____

Allergies _____

Are you dairy sensitive? Yes / No *If you are female, are you pregnant? Yes / No Due date _____

Are you currently under the care of a medical doctor or other type of health care provider for any condition? Yes / No

If yes, what is the condition(s)? _____

Name of doctor or provider _____ Phone _____

Do you exercise? Yes / No * If yes, please describe the activity _____

Intensity _____ How many days a week? _____

Do you use? (how often per day or month) (____) Alcohol (____) Tobacco (____) Coffee (____) Soft Drinks (____) Pain Reliever

Personal History

Pain in body

____Neck pain with difficulty swallowing
____Extreme neck stiffness with pain or shocks in arms or legs when moving neck
____Loss of feeling in inner thighs
____Leg pain that worsens with exercise but is relieved by resting
____Back pain with urinary problems

Types of pain

____Severe pain – interrupts sleep
____Constant pain that doesn't improve by changing positions or lying down

Current conditions

____Unable to balance when walking
____Loss of bowel or bladder control
____Recent major accident such as a fall from height, whiplash or blow to the head
____Recent unexplained weight loss
____Blurred or double vision, dizziness or faintness when neck is in certain positions
____Memory loss after injury
____Recent progressive muscle weakness shaking
____Recent or current fever over 102
____Headaches
____Night sweats

Previously diagnosed conditions/medical history

____Congenital bone or join condition
____Past history of cancer or currently diagnosed with cancer
____Immune suppression as from chemotherapy, organ transplant, etc.
____Rheumatoid arthritis
____Severe degenerative arthritis
____Diabetes
____3 or more months use of steroid medication or IV drugs (past or recent)
____History of compression fractures
____Hepatitis
____History of heart attacks
____Lupus
____History of stroke
____Ankylosing spondylitis
____Osteoporosis or Osteopenia

Are you suffering from any of the symptoms below?

Skin:	Rash	Redness	Itching	Mole changes	Nail changes	Hair changes
Ear,Eyes, Nose, Throat:	Vision problems	Ringing ears	Hearing loss	Nose bleeds	Decreased smell	Bleeding gums
Heart/Lungs:	Cough	Wheezing	Shortness of breath	Swollen hands or feet	Chest pain	Palpitations
Digestion:	Decreased	Abnormal	Vomiting	Diarrhea	Constipation	Rectal bleeding
Urinary / Urgent	Painful	Frequent	Bloody urine	Abnormal	Abnormal	Impotence
Reproductive:	urination	urination	urination	vaginal	menstruation	
Endocrine:	Heat/cold Intolerance	Tremors	Excessive thirst	Fatigue		
Breast:	Lumps	Dimpling	Discharge			

Family History

____AutoImmune disorders ____Cancer ____Heart disease ____Mental Illness ____Stroke
____Arthritis ____Diabetes ____Kidney disease ____Seizure disorder ____Anemia

I hereby authorize the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, chiropractic care or any clinic services that he deems necessary in my case. The nature and purpose of the procedures, possible alternative and possibility of complications will be explained to me by the doctor. I acknowledge that no guarantee or assurance as to the results that may be obtained om the procedure will be give by the doctor. I furthermore authorize him to disclose all or any part of my patient record to any person or corporation, as required by law, or to my health insurance company or worker's compensation carrier in the processing of medical claims on my behalf. I acknowledge that any insurance I have is an agreement between the carrier and me and that I am responsible for any payment of any covered or non-covered services I receive.

_____ _____ _____

Patient / Guardian signature Date Doctor's initials