

# Chiropractic Case History

Name \_\_\_\_\_ Date \_\_\_\_\_

**1. Primary Complaint:** \_\_\_\_\_

**Secondary Complaint:** \_\_\_\_\_

Complaint began when and how? \_\_\_\_\_

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

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

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? \_\_\_\_\_

Is the complaint due to injury or sickness arising out of employment? \_\_\_\_\_

Is the complaint due to injury or sickness arising out of an auto or other accident? \_\_\_\_\_

Days lost from work? \_\_\_\_\_ If due to an accident what was the date of the accident? \_\_\_\_\_

Have you seen any other doctors for this condition? \_\_\_\_\_

**2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:** \_\_\_\_\_

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

### 3. Medications:

Drugs You Now Take:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Muscle Relaxers               | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Birth Control   |
| <input type="checkbox"/> Blood Pressure                | <input type="checkbox"/> Insulin       | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Blood Thinners                | <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Decongestants   |
| <input type="checkbox"/> Cholesterol                   | <input type="checkbox"/> Pain Killers  | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Steroids(allergy/asthma meds) |  | <input type="checkbox"/> Other _____     |

### 4. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

**5. Please Check the appropriate box for any of the following symptoms you now have or have had previously:**

**N = Now P = Previously**

**General**

- |                          |                          |              |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy      |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes     |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness    |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression   |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting     |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue      |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever        |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache     |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss  |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness     |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweats       |
| <input type="checkbox"/> | <input type="checkbox"/> | Tension      |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors      |

**Gastro-Intestinal**

- |                          |                          |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon trouble           |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult digestion     |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive hunger        |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble    |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids             |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver trouble           |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain over stomach       |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor appetite           |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty urinating    |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual bowel problems  |
| <input type="checkbox"/> | <input type="checkbox"/> | Ingestion problem       |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney infection/stones |

**Pain or numbness in:**

- |                          |                          |           |
|--------------------------|--------------------------|-----------|
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | Arms      |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbows    |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands     |
| <input type="checkbox"/> | <input type="checkbox"/> | Feet      |
| <input type="checkbox"/> | <input type="checkbox"/> | Hips      |
| <input type="checkbox"/> | <input type="checkbox"/> | Legs      |
| <input type="checkbox"/> | <input type="checkbox"/> | Knees     |

**Respiratory:**

- |                          |                          |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain/tightness |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough        |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing             |

**Eyes, Ears, Nose & Throat:**

- |                          |                          |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma              |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Colds      |
| <input type="checkbox"/> | <input type="checkbox"/> | Crossed eyes        |
| <input type="checkbox"/> | <input type="checkbox"/> | Earache             |
| <input type="checkbox"/> | <input type="checkbox"/> | Ears ring           |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged thyroid    |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye pain            |
| <input type="checkbox"/> | <input type="checkbox"/> | Light bother eyes   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay fever           |
| <input type="checkbox"/> | <input type="checkbox"/> | Failing vision      |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of smell/taste |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness          |
| <input type="checkbox"/> | <input type="checkbox"/> | Nasal obstruction   |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds          |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems      |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat         |

**Skin:**

- |                          |                          |                 |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema          |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles        |
| <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis       |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rash/hives |

**Muscle & Joint:**

- |                          |                          |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis              |
| <input type="checkbox"/> | <input type="checkbox"/> | Bursitis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot trouble           |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain              |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain              |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff neck             |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain between shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain/swelling    |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful tail bone      |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor posture           |
| <input type="checkbox"/> | <input type="checkbox"/> | Sciatica               |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal curvature       |

**Cardio- Vascular:**

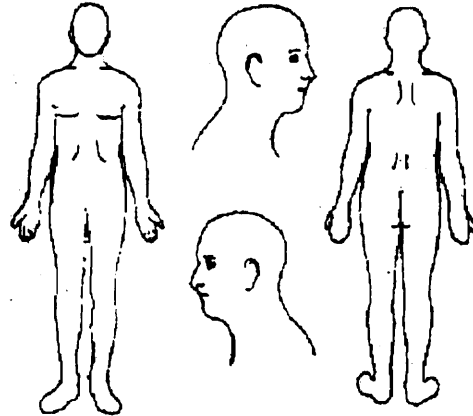
- |                          |                          |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems     |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke             |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain over heart    |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation   |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat   |
| <input type="checkbox"/> | <input type="checkbox"/> | Slow heart beat    |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands cold         |
| <input type="checkbox"/> | <input type="checkbox"/> | Feet cold          |

**For Women Only:**

- |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful menstruation     |
| <input type="checkbox"/> | <input type="checkbox"/> | Cramps or Backache       |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopausal               |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular cycle          |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes              |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual problems/PMS   |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow |

**Place an "X" on the drawing below on areas causing you pain and a letter describing it**

	<b>A = ACHE</b>
	<b>B = BURNING</b>
	<b>S = STABBING</b>
	<b>N = NUMBNESS</b>
	<b>P = PINS &amp; NEEDLES</b>



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 this state's statutes.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_