Chiropractic Case History/New & Renew Patient Information

Date:_____ **Patient #**_____ **Doctor:**_____

Name:_____ Social Security #_____ Marital: M S W D

Address:_____City:_____ State:_____ Zip:_____

Email Address: _____ Home Phone:_____ Cell Phone _____

Age:_____ Birth Date:_____ Spouse Name:_____ How many children?_____

Insurance Co: _____ Occupation:_____ Employer:_____

Work Phone:_____ Would you like a reminder call of your appointment? ___Yes ___ No

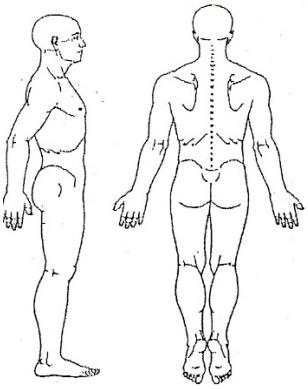
How were you referred to our office? _____(Name) ___ Yellow Pages ___Insurance ___Doctor

___Staff ___Advertisement ___Special Promo ___Speaking Event ___ Other (Explain) _____

Family Medical Doctor's Name/ City:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____ Yes _____ No

HISTORY OF PRESENT ILLNESS: Indicate on body where you have pain or other symptoms.



What describes the nature of your symptoms?

__Sharp __Shooting __Numb

__Dull ache __Burning __Tingling

How are your symptoms changing?

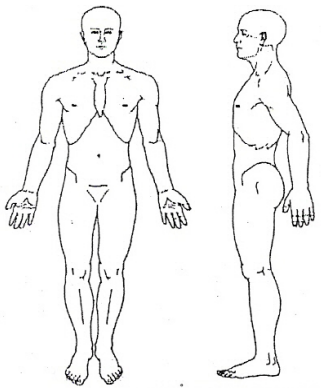
__Getting Better __Not Changing __Getting Worse

Put an "X" on line below to indicate level of problem:

NO SYMPTOMS EXTREME SYMPTOMS

I_____I

0 1 2 3 4 5 6 7 8 9 10



Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? Yes ❒ No If yes, when and describe:_____

_____

Have you seen another doctor for this condition? Yes No

_____

Days lost from work:_____

Female: Is there a possibility that you might be pregnant? _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ → If so, how much per week?_____

Do you use any tobacco products? _____ → Do you smoke?_____ If so, packs per day: _____

Do you take vitamin supplements? _____ → If so, please list:_____

Do you consume caffeine? _____ → If so, how much per day:_____

Do you exercise? _____ → If yes, what is the frequency and type of exercise?_____

_____

What are your recreational activities? _____

PAST MEDICAL HISTORY

Condition/ Symptom	Constantly or Frequently	Sometimes or Occasionally	Condition/ Symptom	Constantly or Frequently	Sometimes or Occasionally	Condition/ Symptom	Constantly or Frequently	Sometimes or Occasionally
Headaches			Joint Swelling			Cough		
Migraines			Dizziness			Chest Pains		
Neck Pain			Nausea			Female Problems		
Shoulder Pain			Weakness			Allergies		
Arm/Hand Pain			Fatigue			Asthma		
Mid Back Pain			Nervousness			Cancer		
Low Back Pain			Insomnia			Osteoporosis		
Hip Pain			Heart Problems			Diabetes		
Leg/Foot Pain			Vision Changes			Hypoglycemia		
Disc Problems			Nose Bleeds			Digestive Problem		
Arthritis			Ringing in Ears			Urinary Problems		
Other Joint Pain			Earaches			Frequent Colds		
Numbness			Hearing Loss			Skin Conditions		

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Excessive Bleeding
__High/Low Blood Pressure
__Osteoarthritis
__Epilepsy
__Pace Maker
__Strokes
__Cancer
__Ruptures
__Coughing Blood
__Eating Disorder
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Depression
__Ulcers

Do you have a history of stroke or hypertension?_____

Have you been treated for any health condition by a physician in the last year? ❒ Yes ❒ No

If yes, describe:_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

What medications or drugs are you taking?_____

_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

FAMILY HISTORY:

Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____

_____

Mother: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____

_____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:_____

_____

FAMILY DISEASES: (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__Tuberculosis _____
__Diabetes _____
__Stroke _____
__Arthritis _____
__Cancer _____
__Asthma _____
__Kidney Disease _____
__Liver Disease _____
__Mental Illness _____
__Heart Disease _____
__Lung Disease _____
__Other _____

Patient/GuardianSignature:_____ **Date**:_____