

CASE HISTORY FORM

Name _____ Date: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referred By _____ E-mail _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Marital Status ___S ___M ___D ___W SSN _____

Spouse's Name _____ Spouse's Occupation _____ # of Children/Ages _____

Have you ever received Chiropractic Care? __Yes __No If yes, approximate date of last visit and doctor's name

Yes	No	(Birth – Age 5)	Patient Comment if answer is Yes	Chiropractor's Comment
		1. Your mother's pregnancy with you		
___	___	Was your mother in good health through her pregnancy?	_____	_____
___	___	Did she have any falls or injuries?	_____	_____
___	___	Did she experience any physical and/or mental abuse?	_____	_____
		2. Birth Process		
___	___	Was the delivery long? Or difficult?	_____	_____
___	___	Forceps? Cesarean?	_____	_____
		Home birth? _____ Hospital Birth? _____		
___	___	Mother given drugs during delivery?	_____	_____
		3. Growth and Development		
___	___	Were you taught how to care for your spine?	_____	_____
___	___	Did you fall out of bed? Did you fall down stairs?	_____	_____
___	___	Were you breastfed?	_____	_____
___	___	Childhood sicknesses?	_____	_____
___	___	Accidents? Falls? Injuries?	_____	_____
___	___	Surgery? Drugs?	_____	_____
___	___	Child abuse?	_____	_____
		Spanking (how?)	_____	_____
		Pulled ear/chin	_____	_____
___	___	Chair pulled out when sat down?	_____	_____
___	___	Were you yanked by your arm?	_____	_____

Yes	No	(Age 5 - Present)	Patient Comment if answer is Yes	Chiropractor's Comment
___	___	Did/do you smoke?	_____	_____
___	___	Did/do you drink any alcohol?	_____	_____
___	___	Have you been in accidents?	_____	_____
___	___	Have you had surgery or organs removed/replaced?	_____	_____
___	___	Drugs? (Prescriptive or non-prescriptive)	_____	_____
___	___	Teeth, eye or hearing problems?	_____	_____
___	___	Exercise regularly?	_____	_____
___	___	Did/do you have occupational stress?	_____	_____
___	___	Physical stress? Mental Stress?	_____	_____
___	___	Hobbies/Sports injuries	_____	_____
___	___	Other traumas or problems?	_____	_____
		Sleeping posture ___ side ___ stomach ___ back	_____	_____

Reason for visiting us

Major complaint _____

Pain or Problem started on _____

Pains are ___ Sharp ___ Dull ___ Constant ___ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? Yes No Sleep? Yes No Routine Yes No

If pregnant, how many weeks? _____ Name of OB/midwife _____

Due date _____ Address or telephone number _____

Is the condition getting progressively worse? Yes No Tests performed _____

Other Doctors seen for condition _____ Diagnoses given _____

Any home remedies? _____

Other symptoms: Please circle

Headaches	Pins and Needles in legs	Fainting
Neck Pain/Stiffness	Pins and Needles in arms	Loss of Smell
Sleeping Problems	Numbness in fingers	Loss of Taste
Mid Back Pain	Numbness in toes	Diarrhea
Low Back Pain	Shortness of Breath	Feet cold
Tension	Fatigue	Hands cold
Irritability	Depression	Stomach upset
Chest Pain	Lights bother eyes	Constipation
Dizziness	Loss of Memory	Loss of Balance
Face Flushed	Ears Ringing or buzzing	Cold Sweats

