



# Family Chiropractic Complex

## Case History

Please print clearly and fill out all answers completely.

Date: \_\_\_\_\_ How did you find out about our office?  Newspaper  Radio  Mail  Other  
 Referred by: \_\_\_\_\_  
 Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Sex:  M  F  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age \_\_\_\_\_  
 Present Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse Social Security #: \_\_\_\_\_  
 Spouse's Place Of Employment: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

Please describe activities your employment requires, such as stooping, lifting heavy objects, typing, etc.

\_\_\_\_\_

List any exercise programs or sports activities in which you participate.

\_\_\_\_\_

Present MD \_\_\_\_\_ Date of last visit \_\_\_\_\_

Reason \_\_\_\_\_

List all surgeries you have had: \_\_\_\_\_

List all current health problems: \_\_\_\_\_

**\*\*Very Important\*\*** Please list ALL medications (prescription and over the counter) you are now taking:

\_\_\_\_\_

Have you ever been under chiropractic care before?  Yes  No

If yes, please give the doctor's name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Describe your chief complaint in detail: \_\_\_\_\_

\_\_\_\_\_

List any automobile accidents and/or major traumas you have suffered and dates: \_\_\_\_\_

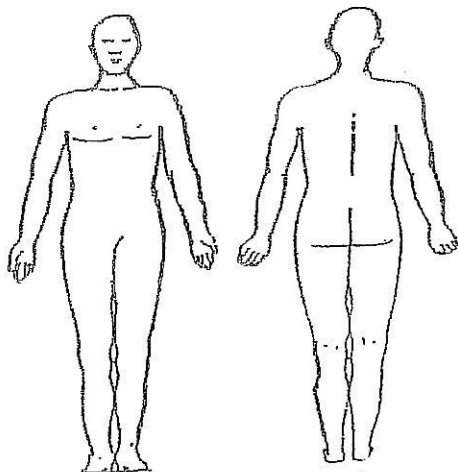
\_\_\_\_\_

Is this an injury?  Yes  No      Did this occur at work?  Yes  No

Is so, are you filing workman's compensation?  Yes  No

If this is an injury, please state how it occurred. \_\_\_\_\_

Mark Area of Pain on the  
Diagram Below:



Date of onset \_\_\_/\_\_\_/\_\_\_

Have you had any other treatment for this condition?  Yes  No

Is so, what type? \_\_\_\_\_

Doctor? \_\_\_\_\_ Results:  None  Fair  Good

Do you have a hard time falling asleep at night?  Yes  No

Do you awaken often during the night?  Yes  No

Are you allergic to pollen?  Yes  No

Do you wear any inserts in your shoes or built up shoes?  Yes  No

### System Review

Please check those symptoms or conditions you have or have had in the last several years.

#### GENERAL

Irritability  
 Depression

Crave Sweets  
 Frequent sinus trouble

Abnormal hair loss or growth  
 Fatigue

#### HEAD

Headache  
 Migraine  
 Tension  
 Head feels heavy  
 Loss of memory

Fainting  
 Loss of smell  
 Epileptic seizures  
 Frequent ear infections  
 Inner ear trouble

Dizziness  
 Pain in ears  
 Ringing in ears

#### EYES

Blinded by lights

Light bothers eyes

Floating spots

#### NECK

Pain in neck

Stiff neck

Grating or popping sounds in neck

ARM AND HANDS

Sensation of pins and needles in arms     Hands cold     Loss of grip or strength  
 Sensation of pins and needles in fingers     Numbness in hands and/or fingers

MID-BACK/LOW BACK

Pain between shoulder blades     Pain in shoulder joints (  Right  Left )     Low back pain

HIPS, LEGS, AND FEET

Pain in hip joint (  R  L )     Feet feel cold     Swollen ankles (  R  L )  
 Pain down leg (  R  L )     Feet tire and ache easily     Numbness of leg or feet (  R  L )  
 Pins and needles in legs (  R  L )     Cramps in feet or legs (  R  L )

INTESTINES

Constipation     Diarrhea     Colitis     Distress from fatty or greasy foods (nausea)

GASTROINTESTINAL

Burping or Bloating     Sour Stomach     Gas     Nausea     Nervous stomach

CARDIOVASCULAR

Low blood pressure     High blood pressure     Pain over heart  
 Heart attack     Irregular heartbeat

GENITOURINARY

Kidney infection     Bladder infections     Inability to control urination  
 Need to get up at night to urinate     Asthma

WOMEN ONLY

Irregular periods     Miscarriage     Premenstrual breast tenderness  
 Menstrual cramps     Premenstrual depression     Menopause, date \_\_\_\_\_  
 Loss or diminished sex drive     Hysterectomy, complete \_\_\_ or partial \_\_\_

MEN ONLY

Need to get up at night to urinate     Loss or diminished sex drive     Prostate trouble

Please list any other information that you think we should be aware of in handling your case:

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

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date