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: _____
_____
_____

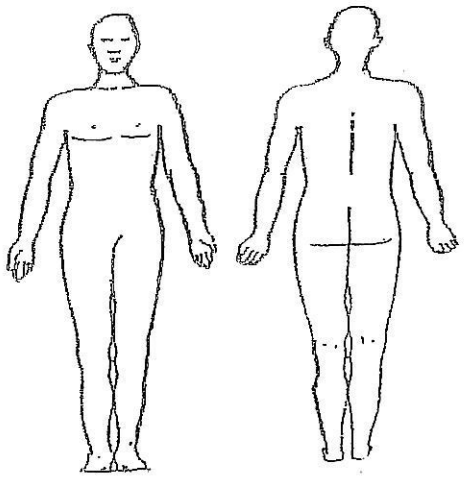
List any automobile accidents and/or major traumas you have suffered and dates: _____
_____
_____

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 __Crave Sweets __Abnormal hair loss or growth
__Depression __Frequent sinus trouble __Fatigue

HEAD

__Headache __Fainting __Dizziness
__Migraine __Loss of smell __Pain in ears
__Tension __Epileptic seizures __Ringing in ears
__Head feels heavy __Frequent ear infections
__Loss of memory __Inner ear trouble

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