CASE HISTORY

Name: ___________________________________

Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity Minimal Severe	Frequency (% of week) Occasional Constant
a.________________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b.________________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c.________________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d.________________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Please mark the figures where you experience pain or discomfort.

When did your symptoms begin? (onset date)

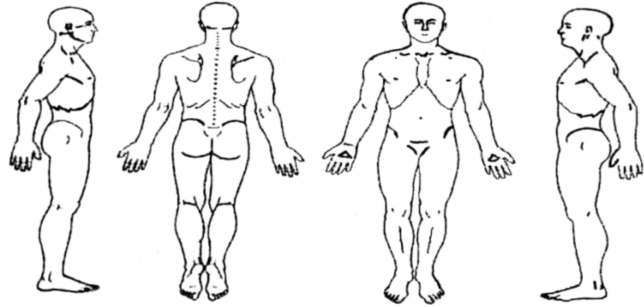
a) _______________ b) _______________

c) _______________ d) _______________

Have you experienced these before?

a.) Yes No b.) Yes No

c.) Yes No d.) Yes No



Please answer question corresponding with Condition/Problem listed above:

Symptoms (**a**.) are worse in the (circle what applies) Morning / Afternoon / Night / Increase during the day / Same all day / Decrease during the day

Symptoms (**a**.) is (circle all that apply) Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

How did your symptoms begin? (**a**.) ____

Has your condition/problem? (**a**.) Improved _____ Gotten Worse _____ Stayed the same since its onset _____

Circle the things that make your condition/problem worse: (**a**.) Bending / Lying / Walking / Standing / Sitting / Movement / Twisting / Lifting

Is there anything you can do to relieve the problems? (**a**.) No ____ Yes ____ Describe: __________________________________

Symptoms (**b**.) are worse in the (circle what applies) Morning / Afternoon / Night / Increase during the day / Same all day / Decrease during the day

Symptoms (**b**.) is (circle all that apply) Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

How did your symptoms begin? (**b**.) ____

Has your condition/problem? (**b**.) Improved _____ Gotten Worse _____ Stayed the same since its onset _____

Circle the things that make your condition/problem worse: (**b**.) Bending / Lying / Walking / Standing / Sitting / Movement / Twisting / Lifting

Is there anything you can do to relieve the problems? (**b**.) No ____ Yes ____ Describe: __________________________________

Symptoms (**c.**) are worse in the (circle what applies) Morning / Afternoon / Night / Increase during the day / Same all day / Decrease during the day

Symptoms (**c**.) is (circle all that apply) Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

How did your symptoms begin? (**c**.) ____

Has your condition/problem? (**c**.) Improved _____ Gotten Worse _____ Stayed the same since its onset _____

Circle the things that make your condition/problem worse: (**c**.) Bending / Lying / Walking / Standing / Sitting / Movement / Twisting / Lifting

Is there anything you can do to relieve the problems? (**c**.) No ____ Yes ____ Describe: __________________________________

Symptoms (**d**.) are worse in the (circle what applies) Morning / Afternoon / Night / Increase during the day / Same all day / Decrease during the day

Symptoms (**d.**) is (circle all that apply) Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

How did your symptoms begin? (**d**.) ____

Has your condition/problem? (**d**.) Improved _____ Gotten Worse _____ Stayed the same since its onset _____

Circle the things that make your condition/problem worse: (**d**.) Bending / Lying / Walking / Standing / Sitting / Movement / Twisting / Lifting

Is there anything you can do to relieve the problems? (**d**.) No ____ Yes ____ Describe: __________________________________

CASE HISTORY CONTINUED

Have you been treated for any of these before? No ___ Yes ___ How long ago? a. __________ b. __________ c. __________ d. __________

What treatment did you receive? ____

Results of previous treatment Good __________ Poor __________ Comments ____

Is this condition(s) interfering with (please mark corresponding symptom (a,b,c,d)?

Work __________ Sleep __________ Daily Routine __________ Recreation ____________

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment.) **Yes** **No**

Approximate date of last MD / DO treatment? ____

Family Physician: ____ (Note: We may send your health information to this provider.)

Address: ____ Phone: ____

What operations have you had? ____ When: ____________________

____ When: ____________________

____ When: ____________________

Serious Illness: ____ When: ____________________

Accidents/Injuries: ____ When: ____________________

____ When: ____________________

Infectious Disease(s): ____ When: ____________________

What medications or drugs are you taking? _________________________________ How much: _______________ How long: _________________

_________________________________ How much: _______________ How long: _________________

_________________________________ How much: _______________ How long: _________________

_________________________________ How much: _______________ How long: _________________

Cardiac Devices? **Yes** **No** When: ____

Hip/Knee Replacement? **Yes** **No** When: ____

List any other major injuries you have had, other than those mentioned above: ____

____

Is there any other musculoskeletal problems? **Yes** **No** ____

Is there any neurological problems? **Yes** **No** ____

What is your goal in our office? ____

Is there anyone else in your family that you think might benefit from Chiropractic Care? ____

____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature: ____ **Date:** ________________________

Doctor Notes: ____

____

____

____

____

____

____

____

____

____

____