**File #:** _____

# CASE HISTORY

**Date:** _____

**Name:** _____ **Email:**_____

**Address:** _____ **Postal Code:** _____

**Phone:** _____ **Cell:** _____

**Gender:** _____ **Birthdate:** _____ **Care Card #:** _____

***Would you like an appointment reminder:*** ☐ **YES** ☐ **NO** ☐ Phone call 24 hrs before appt

**Circle One: Text / Email** ☐ 1 hr before appt ☐ 24 hrs before appt ☐ 2 days before appt

**Would you like to receive a monthly newsletter by email?** ☐ Yes ☐ No

**Who may we thank for referring you to our office?** _____

**Please describe your chief problem:**_____

**How long has this been a problem?**_____**Have you experienced similar symptoms in the past?** _____

**If 'YES', please describe:**_____

**Is this problem generally:** ☐ getting worse ☐ staying the same ☐ getting better

**Have you recently experienced the following - please check YES or NO**

| | YES | NO |
|---|---|---|
| Physical trauma | ☐ | ☐ |
| History of cancer | ☐ | ☐ |
| Fevers | ☐ | ☐ |
| Weight loss (unexplained) | ☐ | ☐ |
| Pain that wakes you up | ☐ | ☐ |
| Significant Cortisone use | ☐ | ☐ |
| Recent infection | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Lower limb weakness | ☐ | ☐ |

**Type of pain *(circle)***

Numbness

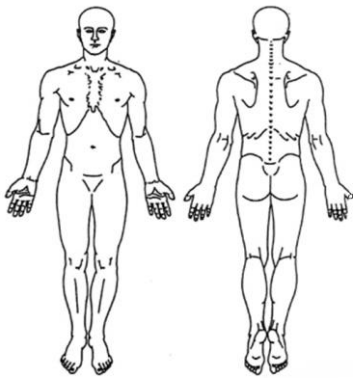
Tingling

Dull ache

Stabbing

Shooting

**Where do you hurt? *(circle)***



**To help us track of your progress, please list 3 activities (such as bending, walking, reaching etc.) you are either unable to perform or are having difficulty performing due to your chief problem. Please score your level of difficulty from 0-10. 0 = No difficulty 10 = Unable to perform**

| | Daily Activities Difficult to Perform | Score 0-10 |
|---|---|---|
| **1** | | |
| **2** | | |
| **3** | | |

**Office Use Only:**

**Aggravating factors:**

**Relieving factors:**

**Previous chiropractic care:**

**Family History:**

☐ Intake Form Checked

☐ Scanned into Jane