File #: _____

CASE HISTORY

Date: _____

Name: _____ **Email:**_____

Address: _____ **Postal Code:** _____

Phone: _____ **Cell:** _____

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

Appointment Reminder: **YES ☐ NO ☐ Circle One: Email / Text / Phone**

☐ Phone call 24 hrs before appointment ☐ Text or Email 1 hr before appointment

☐ Text or Email 24 hrs before appointment ☐ Text or Email 2 days before appointment

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

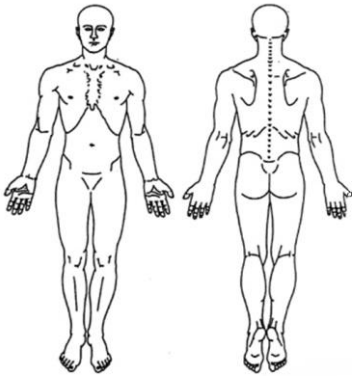
Tingling

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: