

Case History

Name: _____

Date _____

Address: _____ Email: _____

Phone: _____ Cell: _____

Appointment reminder: YES NO (circle one: email / text / phone)

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| History of cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Fevers | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight loss (unexplained) | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain that wakes you up | <input type="checkbox"/> | <input type="checkbox"/> |
| Significant Cortisone use | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Lower limb weakness | <input type="checkbox"/> | <input type="checkbox"/> |

Office use only

Type of pain (*circle*)

Where do you hurt? (*circle*)

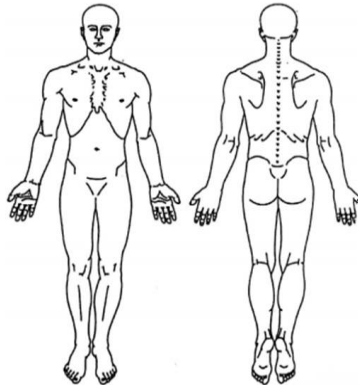
Numbness

Tingling

Dull ache

Stabbing

Shooting



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 | | |

Aggravating factors:

Relieving factors:

Previous chiropractic care:

Family History: