

Chiropractic Case History/Patient Information

Date: ____/____/____ **Patient #** _____ **Doctor:** _____

Name: _____ **Social Security #** _____ **Home Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Age: _____ **Birth Date:** ____/____/____ **Marital:** M S W D **Cell Phone:** _____

Occupation: _____ **Employer:** _____

Office Phone: _____ **E-mail address:** _____

May we send you appointment reminders via email or text message? email text(____) _____ No

Spouse: _____ **Spouse's Occupation:** _____

How many children? _____ **Names and Ages of Children:** _____

Name of Nearest Relative: _____ **Phone:** _____

Who referred you to our office (how did you find us)? _____

Have you seen a chiropractor before? Yes No If yes, when last _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Itasca Health Care

Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____ **Is this due to:** Auto _____ Work _____

Other _____ **Have you ever had the same or a similar condition?** [] Yes [] No

If yes, when & how it started: _____

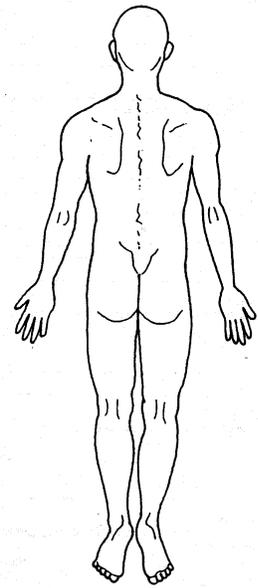
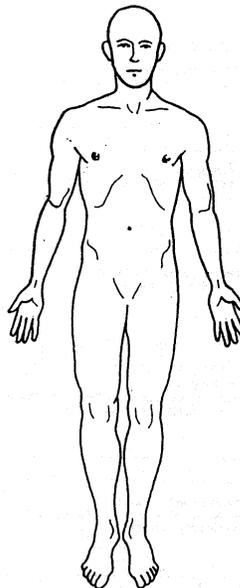
Today, how severe is the pain? (no pain) **0 1 2 3 4 5 6 7 8 9 10**(extreme pain). On average: ____/10

Are you experiencing any of these feelings? Aching

Burning Stabbing Shooting Dull Tingling

Numbness Clicking Stiffness Cramping

Place an "X" on the body image where you are having problems today: →



PATIENT NAME _____ DATE ____/____/____

Days lost from work:_____ Date of last physical examination:_____

Have you had any X-rays or MRI's taken of this area? Yes No If yes, when _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (with dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, what : _____

What medications or drugs are you taking (and what for?)_____

What vitamins/supplements are you taking?_____

Do you have any allergies to any medications? Yes No If yes, describe:_____

Do you have any allergies of any kind? Yes No If yes, describe:_____

WOMEN:Are you pregnant? Yes No Not sure Date of your last menstrual period _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **NOW** or **P** if you have had these conditions in the **PAST**. Leave blank if never had.

N = Now P = Previously

- | | |
|--|-----------------------------------|
| Headaches _____ (<input type="checkbox"/> daily <input type="checkbox"/> wkly <input type="checkbox"/> monthly) | Depression _____ |
| Neck Pain _____ | Sleep Trouble/apnea _____ |
| Neck Stiffness _____ | Chest pains/tightness _____ |
| Hands Cold _____ | Breathing Problems _____ |
| Numb Fingers _____ | Fatigue _____ |
| Weakness in arms _____ | Joint pain/swelling _____ |
| Shoulder/Arm Pain _____ | Rheumatoid Arthritis _____ |
| Sinus Problems _____ | Osteoarthritis _____ |
| Loss of Smell _____ | Broken Bones/Fractures _____ |
| Loss of Taste _____ | Osteoporosis _____ |
| Loss of Memory _____ | Low Back Pain _____ |
| Lights Bother Eyes _____ | Feet Cold _____ |
| Ears Ring _____ | Numb Feet _____ |
| Fevers _____ | Weakness in legs _____ |
| Frequent Colds _____ | Circulation problems _____ |
| High Blood pressure _____ | Restless Legs _____ |
| Low Blood pressure _____ | Alcoholism _____ |
| Dizziness _____ | Drug Addiction _____ |
| Fainting _____ | HIV Positive _____ |
| Seizures/Epilepsy _____ | Diabetes Type1[] Type2 [] _____ |
| Muscle Spasms _____ | Excessive Urination _____ |
| Loss of Balance _____ | Indigestion _____ |
| Anxiety _____ | Irregular bowel patterns _____ |
| Stress _____ | Weight Loss/Gain _____ |
| Irritability _____ | |

	N = Now	P = Previously
Ulcers	_____	Excessive Bleeding _____
Gall Bladder Problems	_____	Eating Disorders _____
Blood in stool or urine	_____	Heart Disease _____
Coughing up blood	_____	Pacemaker _____
Difficulty Urinating	_____	Stroke _____
Menstrual Discomfort	_____	Cancer _____
Hot Flashes	_____	type: _____

SOCIAL HISTORY:

Describe any type of exercising you do: _____

Do you exercise as above Regularly (4+week) Occasionally (1-2x/week) Rarely

Do you drink alcohol >4 times/week 1-2 times/week 1-2 times/month Never

Use illegal drugs No Yes type: _____

Rate your stress level (0=No stress, 10=Very high) _____/10

Use tobacco 2packs/day 1pack/day ½ pack/day Occasionally Chew Quit Never

Cups caffeinated coffee/day= _____

Soda pop/ day: _____

Servings of dairy _____/ day

Fast food _____/week

Serving Fruits and Vegetables _____/day

Have trouble sleeping Every night Few times/week Few times/month Rarely

What position do you sleep in? Back Side with legs together Side with one leg up Stomach

How many hours per night do you sleep? _____

How many hours per week do you work? _____

What percent of your work day do you spend sitting on average? _____

Describe your job duties: _____

FAMILY HISTORY: Do you have any relatives who suffer from any of these conditions?
If so, put their relation to you on the line.

Arthritis _____
Gout _____
Back trouble _____
Disc problems _____
Sciatica _____
Poor posture _____
Scoliosis _____
Osteoporosis _____
Cancer _____
Diabetes (type 1) _____
Diabetes (type 2) _____
Heart disease _____
Heart valve problems _____
Kidney problems _____
Insomnia _____
Emphysema _____

High Blood pressure _____
Migraines _____
Other headaches _____
Depression _____
Anxiety _____
Asthma _____
Allergies _____
Sinusitis _____
Autism/ASD _____
Sensory issues _____
Ear infections _____
Eczema _____
IBS _____
Gluten intolerance _____
Constipation _____
Gallstones _____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____