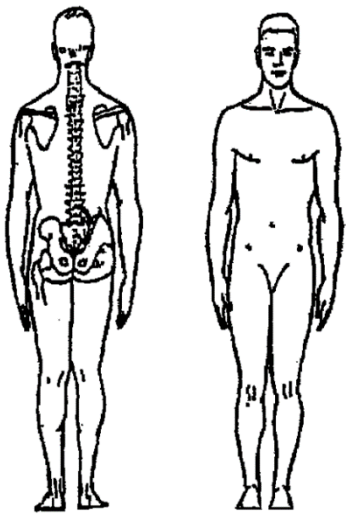
PATIENT NAME: _____ CHART NO: _____

CASE HISTORY



What is your chief complaint/reason for visit? _____

- How long have you had this? _____
- Did it come on **GRADUALLY** or **SUDDENLY**? (*Circle One*)
- Have you had this before? **NO** or **YES**, if yes, then when? _____
- What makes it better? _____
- What makes it worse? _____
- If you are in pain, please indicate area on the drawing: ⟶
- Pain level of **0 to 10** (*where 0 = No Pain and 10 = Worst Pain*): _____
- Describe what it feels like (*circle all that apply and/or fill in blank*):
  - **ACHE BURN DULL NUMBNESS SHARP STABBING TINGLING OTHER**: _____
- How often does it occur? (Circle One): **ALL THE TIME** or **MOST OF THE TIME** or **SOME OF THE TIME** or **OFF and ON** or **RANDOM** or **RECURRING**
- Does the pain radiate, shoot, or refer to other parts of your body? ☐No ☐Yes If so, please describe: _____
- When are symptoms worse? *(circle all that apply)* **MORNING AFTERNOON EVENING ALWAYS**
- If you were to guess, what do you think is causing your complaint(s)? _____

What activity is most affected by your condition? (*What do you miss most*?): _____

_____

Review of Systems - Please mark if you have any of the following:

Constitutional	Musculoskeletal	Neurological	Cardiovascular	Respiratory
○ Fever	○ Back Pain	○ Sudden Numbness	○ High Blood Pressure	○ Asthma
○ Weight Loss	○ Headaches	○ Sudden Headache	○ Heart Disease	○ COPD
○ Obesity	○ Extremity Pain	○ Loss of Sensation	○ Arterial Aneurysm	○ Common Cold
○ Loss of Appetite	○ Bone Demineralization	○ Confusion	○ Angina	○ Emphysema
○ Fatigue	○ Unstable Fracture	○ Dizziness	○ Irregular Heart Beat	○ Pneumonia
○ Anxiety	○ Spinal Infection	○ Slurred Speech	○ Bleeding Disorder	○ Cancer
○ Allergies	○ Spinal Bone Tumors	○ Loss of Balance	○ Heart Attack	○ Pneumothorax

Eyes	E, N, M, T	Genitourinary	Gastrointestinal	Disease History
○ Vision Troubles	○ Hearing Loss	○ Kidney Infection	○ Diarrhea	○ Stroke
○ Double Vision	○ Tinnitus	○ Loss Bladder Control	○ Blood in Stool	○ Heart Attack
○ Night Blindness	○ Vertigo	○ Urine Color Change	○ Abdominal Pain	○ Diabetes
○ Glaucoma	○ Nose Bleeds	○ Painful Urination	○ Liver/Gall Condition	○ Cancer
○ Cataracts	○ Dry Mouth	○ Urine Leakage	○ Nausea/Heartbum	○ HIV/AIDS
○ Discharge	○ Change in Taste	○ Urgency	○ Loss Bowel Control	
○ Droopy Eyelids	○ Bleeding Gums	○ Blood in Urine	○ Prostate Problems	

Any medical conditions not mentioned above? _____

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

Describe condition: _____

PATIENT NAME: _____ CHART NO: _____

Surgical History:

1. _____ Year: _____ 4. _____ Year: _____
2. _____ Year: _____ 5. _____ Year: _____
3. _____ Year: _____ 6. _____ Year: _____

- Do you have metal or medical implant(s) in your body? □Yes or □No Note: _____
- Have you ever had chiropractic care in the past? □Yes or □No
  - If yes, what was your response to the care you received? _____
- Any known allergies? □ No, □ Yes (Please indicate: □ Food, □ Medication, □ Other: _____
- Do you wear glasses? □ No, □ Yes and/or Contact lenses? □ No, □ Yes

Of the following list of habits, please indicate amount and how often: (daily, weekly, cups, packs, etc.…)
• Do/Did you smoke (cigarettes/e-cigarettes/vaping/etc.)? Yes □ No □ Packs/Day? ____ Quit? □ year: _____
• Chew tobacco? Yes □ No □ Do you drink alcohol? Yes □ No □ How much and how often? _____
• Do you drink Coffee or Caffeinated beverages? Yes □ No □ What/How much/How often? _____

Please circle the ones below that apply for each category				
How many times do you exercise per week?	What's that?	1-2 x per week	3-4 x per week	5-7 x per week
How many hours do you sleep per night?	Less than 6 hours	6-7 hours	7-8 hours	8 or more hours
How much water do you drink per day? (**Goal is half your body weight in ounces*)	Less than 16 oz (< 1/2 quart)	16-32 oz (1/2-1 quart)	32-64 oz (1-2 quarts)	More than 64 oz (> 2 quarts)

Medications/Supplements: Check and list all medications and supplements that you are currently taking:

	Name of Medication/Supplement	**Year Started**
□ Antacid		
□ Antibiotic		
□ Anti-Anxiety		
□ Anti-Depressant		
□ Anti-Inflammatory		
□ Blood Pressure		
□ Chemotherapy		
□ Cholesterol		
□ Diabetes/Blood Sugar		
□ Hormone Replacement (HRT)		
□ Birth Control/Oral Contraceptives		
□ Over the Counter Meds *(Tylenol, Ibuprofen, Aspirin, Aleve, etc.…)*		
□ Other:		
□ **SUPPLEMENT(S)/VITAMINS:**		

FEMALES: Are you or might you be pregnant? □ **NO,** □ **YES → Due Date: _____**	Date of onset of last period: _____	Have you had a hysterectomy? □ **NO** □ **YES** Year: _____

Today's Date: _____ Signature: _____

(parent/guardian signature if applicable)