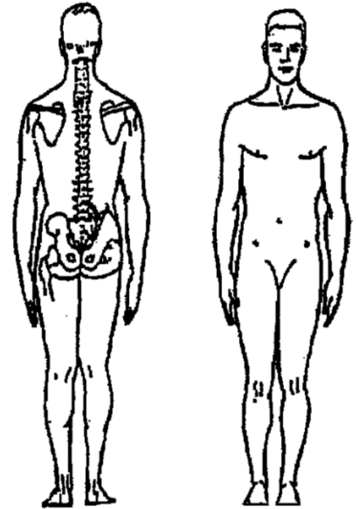
PATIENT NAME: ______________________________________ CHART NO: _________________________

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/Heartburn	○ 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)