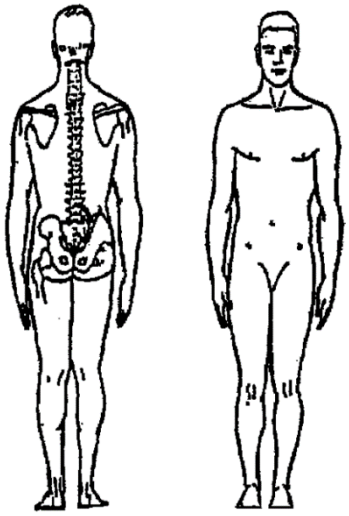
PATIENT NAME: _____ CHART NO: _____

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**: _____
- 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?)**: _____

_____

Have you suffered any Accident/Injury/Major Event in your life? (date and explain) _____

_____

Medical History *Please put an "**X**" in the box as it applies if you have the following **NOW** or in the **PAST**:*

NOW	PAST	CONDITION	NOW	PAST	CONDITION	NOW	PAST	CONDITION
		Arthritis			Emphysema			Nervousness
		Asthma/Hay Fever			Epilepsy			Neuritis
		Back Trouble			Headaches			Neuralgia
		Bursitis			Heart Trouble			Pinched Nerve
		Cancer			High Blood Pressure			Scoliosis
		Concussion			Insomnia			Sinus Trouble
		Constipation			Kidney Trouble			Stomach Trouble
		Diabetes			Liver Trouble			Other:
		Disc Problem			Migraine			

Of the following list of habits, please indicate amount and how often: (daily, weekly, cups, packs, etc.…)

- Do you smoke (cigarettes/e-cigarettes/vaping/etc.)? Yes ☐ No ☐ What and how much? _____
- Do you drink alcohol? Yes ☐ No ☐ How much and how often? _____ Chew tobacco? Yes ☐ No ☐
- Do you drink Coffee or Caffeinated beverages? Yes ☐ No ☐ What/How much/How often? _____

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: _____

PATIENT NAME: _____ CHART NO: _____

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)

- Have you been treated by a physician for this or any health condition in the last year? ☐Yes or ☐No
  - Describe condition: _____
- Have you ever had chiropractic care in the past? ☐Yes or ☐No
  - If yes, what was your response to the care you received? _____
- Surgical History:
  1. _____ Date: _____
  2. _____ Date: _____
  3. _____ Date: _____
  4. _____ Date: _____
- Please list the location of major scars: _____
- Do you have or ever had a metal implant or pacemaker? ☐Yes or ☐No

Medications: Check and list all medications that you are currently taking with the date you began taking them

	Name of Medication	**Date Started**
☐ Antacids		
☐ Antibiotics		
☐ Anti-Depressants/Anti-Anxiety		
☐ 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:		

Supplements: List all Vitamins/Minerals/Herbs/Homeopathics that you currently taking, why, and how long

Name	**What is it for?**	**How long?**

Do you have any known allergies? ☐ No, ☐ Yes (Please indicate: ☐ Food, ☐ Medication, ☐ Other: _____
Do you wear glasses? ☐ No, ☐ Yes Contact lenses? ☐ No, ☐ Yes
Have you ever had a detached retina? ☐ No, ☐ Yes
Is there anything you want to add that hasn't been addressed above? ☐ No, ☐ Yes **If so, please do:** _____
_____
_____

Today's Date: _____ Signature: _____
(parent/guardian signature if applicable)