

Confidential Patient Case History

Patient Name: _____ Date: _____ GCC# _____

Patient Date of Birth: ____/____/____

Height: _____ Weight: _____ Blood Pressure: _____

List any ALLERGIES: Medication/Food/Environment

List any SURGERIES: (Date of surgery)

List past MEDICAL HISTORY conditions:

List MEDICATION(S) and Dosage Amount(s) Use back of sheet for additional space) OR Provide list

List your FAMILY HISTORY: (Mother-Father-Grandparents)

Do you have High Blood Pressure? [Y] or [N]

Do you have Diabetes? [Y] or [N]

In general, would you describe your overall health as...

Excellent Very good Good Fair Poor

Have you ever had previous chiropractic care? **YES/NO** If yes, date of last care: _____

Have you had any auto or other major accidents? **YES/NO**

Describe: _____

Is this an Industrial Accident Case? **YES/NO**

Date of last physical examination: _____

Do you smoke? **YES/NO** If yes, how often?: _____

Do you drink alcohol?: **YES/NO** If yes, how many per day?: _____

Do you drink caffeine?: **YES/NO** If yes, how many per day?: _____

Do you exercise?: **YES/NO** If yes, what forms and how often?: _____

Are you pregnant?: _____

Dental Visits: __ Every six months __ Yearly __ Emergency only __ Complete dentures

Age of mattress: _____ Comfortable/Uncomfortable Do you use a bed board?: _____

Are you wearing: __ Heel lifts __ Sole lifts __ Inner soles __ Arch supports

Have you ever: *Describe Briefly*

Been knocked unconscious?: **YES/NO** _____

Used a cane, crutch or other support?: **YES/NO** _____

Been treated for a spine or nerve disorder?: **YES/NO** _____

Had a fractured bone?: **YES/NO** _____

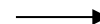
Been hospitalized for anything other then surgery?: **YES/NO** _____

Do you: Now take vitamins or minerals?: **YES/NO** _____

(Use back of sheet for additional space)

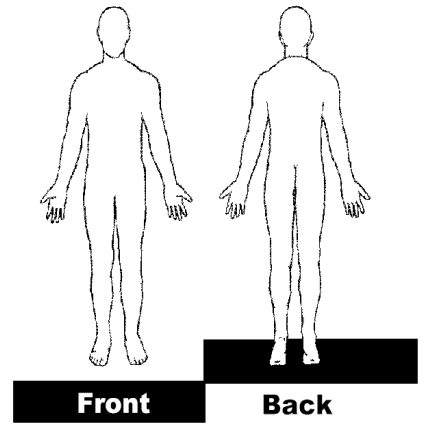
Are you currently seeing any other providers for other current health conditions? YES or NO

Please list the problem(s), date problem(s) began and Provider(s) treating you for the condition(s):



Patient Name _____ Date _____ GCC# _____

Please mark your areas of pain on the diagram



Main reason(s) for consulting the office:

- ____ Become pain free
- ____ Explanation of my condition
- ____ Learn how to care for my condition
- ____ Reduce symptoms
- ____ Resume normal activity level

Primary Condition:

Describe your symptoms (specify right side-left side-front-back) _____

Date problem began?: _____ **Have you had this condition in the past?: YES / NO**

How did this begin?: (falling, lifting, etc.): _____

How is your condition changing?: ____ Getting Better ____ Getting Worse ____ Not Changing

How often do you experience your symptoms?:
____ Constantly (76-100%) ____ Frequently (51-75%)
____ Occasionally (26-50%) ____ Intermittently (0-25%)

Describe the nature of your symptoms: __ Burning __ Dull __ Numb __ Radiating __ Sharp __ Shooting __ Stabbing
__ Tingling __ Tightness __ Throbbing __ Other: _____

Rate your pain on a scale 1 to 10 (0=no pain and 10=excruciating pain):

Past 24 hours: 1 2 3 4 5 6 7 8 9 10

Past week: 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition? (working, exercise, etc.): _____

What makes your pain better? (ice, heat, stretching, rest, etc.): _____

How much have your symptoms interfered with your daily activities? None Minimal Light Moderate Severe

Secondary Condition:

Describe your symptoms (specify Right side-left side-front-back) _____

Date problem began?: _____ **Have you had this condition in the past?: YES / NO**

How did this begin?: (falling, lifting, etc.): _____

How is your condition changing?: ____ Getting Better ____ Getting Worse ____ Not Changing

How often do you experience your symptoms?:
____ Constantly (76-100%) ____ Frequently (51-75%)
____ Occasionally (26-50%) ____ Intermittently (0-25%)

Describe the nature of your symptoms: __ Burning __ Dull __ Numb __ Radiating __ Sharp __ Shooting __ Stabbing
__ Tingling __ Tightness __ Throbbing __ Other: _____

Rate your pain on a scale 1 to 10 (0=no pain and 10=excruciating pain):

Past 24 hours: 1 2 3 4 5 6 7 8 9 10

Past week: 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition? (working, exercise, etc.): _____

What makes your pain better? (ice, heat, stretching, rest, etc.): _____

How much have your symptoms interfered with your daily activities? None Minimal Light Moderate Severe

I certify that the above information is correct and I request services.

Patient Signature: _____ **Date:** _____