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:
____

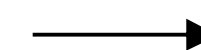
List MEDICATION(S) and Dosage Amount(s) Use back of sheet for additional space) OR Provide list
____

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

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

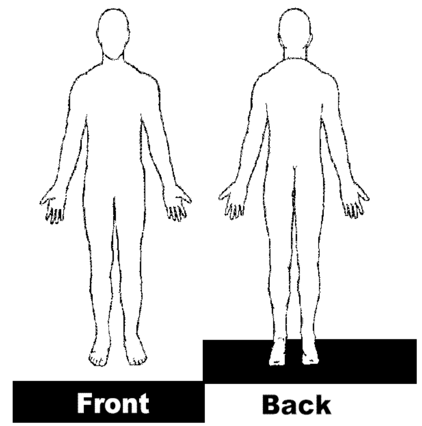
In general, would you describe your overall health así
Excellent Very good Good Fair Poor
Have you ever had previous chiropractic care? **YES/NO** If yes, date of last care:___________
Have you had any auto or other major accidents? **YES/NO**
Describe:____
Is this an Industrial Accident Case? **YES/NO**
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:**__________________