….. First Choice Chiropractic …..

CASE HISTORY

Full Name: ____ **Date of Birth** _____________________

History of Present Injury/ Illness: List the complaints you are here to have treated, in order of importance & list how long you have had each:

1.____________________________ how long?_______________ 2.__________________________________ how long? ______________
3.____________________________ how long?_______________ 4.__________________________________ how long?_______________
5.____________________________ how long?_______________ 6.__________________________________ how long?_______________

Please fill out the following for the primary condition for which you are here to be treated:

Circle the number that best matches your level of pain at its worst (0 = no pain, 10 = most severe) 0 1 2 3 4 5 6 7 8 9 10

1. Is your condition related to an accident? [] Yes [] No If yes: Date of Accident __________________ [] Auto [] Work related [] Other
2. How did pain or condition start? ____ When did it start? _________________________
3. What words **best describe** your present condition? (example: sharp, burn) ____
4. **When** is your condition **most** severe? _______________________________________ **least** severe? __________________________________
5. What makes your condition feel **worse**? ______________________________________ feel **better**? ____________________________________
6. What activities are difficult because of your condition? ____
7. Have you seen any other health care provider for your present condition? [] Yes [] No If yes who?___________________________________
8. Personal habits: [] Tobacco [] Alcohol [] Vitamins [] Exercise [] Recreational Drugs [] Medications and reasons _____________________
9. Family history related to present condition: ____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

Female History: **Are you pregnant at this time? []** Yes [] No [] Unsure but could be
Date of last menstrual cycle ___________________________ [] regular [] irregular Using birth control pills [] Yes [] No

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Are you experiencing or do you have any of the following: (check all that apply)

[] A sore that wont heal
[] Difficulty swallowing
[] Persistent cough/hoarseness
[] Any bleeding/discharge
[] Lump/thickening anywhere
[] Wart/ mole changes
[] Bladder/ bowel problems
[] Night pain
[] Weight loss without trying
[] NONE OF THESE

<u>Review of Systems</u>

In addition to the symptoms/dysfunction listed above, are you experiencing any of the following?

Neuromusculoskeletal System (check all that apply)

[] Sensory changes
[] Facial drooping
[] Loss of balance
[] Seizures
[] Headache
[] Atrophy
[] Vision Trouble
[] Memory Loss
[] Dizziness
[] Anxiety
[] Joint deformity
[] Mood swings
[] Speech problems
[] Twitches
[] Limited range of motion
[] Psychiatric disorders
[] Joint locking
[] Muscle weakness
[] Stiffness
[] Depression
[] Difficulty walking
[] Joint swelling
[] Numbness
[] Tremors
[] Concussion
[] Lack of coordination
[] Popping noises
[] Extremity deformity
[] NONE OF THE ABOVE

Cardiovascular System (check all that apply)

[] Chest pain
[] Dizziness
[] Fainting
[] Ankle swelling
[]Known vascular disease
[] Jaw Pain
[] Phlebitis
[] Pin Stroke
[] Mitral valve prolapse
[] Changes in skin color
[] Previous stroke
[] Varicose veins
[] Blood clots
[] Carotid blockage
[] Shortness of breath
[] Hypertension
[] NONE OF THE ABOVE

Past History List any surgeries you have had (including appendix, tonsils, wisdom teeth etc)

1.___________________________________ When? __________ 2. _______________________________ When?_____________________
3.___________________________________ When?____________ 4. _______________________________ When? _____________________

List any hospitalizations other than surgeries, when and what for: ____
List any diagnosed conditions : (example diabetes, cancer, etc) ____
List any current Dr.s & conditions not previously listed: ____
List any major or minor falls or accidents & when occurred____
List any cracked or broken bones and when occurred ____

Patient Signature ____ **Date** _______________