Spinal Health & Wellness
at Family Chiropractic

Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id	date

1 PATIENT INFORMATION

last name	first name	m.i.

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐ yes ☐ no

What services interest you? (mark all that apply)

- ☐ injury prevention
- ☐ treatment for pain
- ☐ patient education classes
- ☐ balance and coordination training
- ☐ spinal and body alignment
- ☐ body composition counseling
- ☐ range of motion, mobility, or flexibility therapy
- ☐ strengthening and stamina exercise
- ☐ nutritional and supplement counseling
- ☐ other: ____________________

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ cold

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1	2	3	4	5	6	7	8	9	10
no pain or discomfort	slight discomfort	pain that does not affect my activity	pain that affects my daily activities	pain that prevents performing my daily activities	pain that limits my work schedule	pain that prevents working at all	pain that prevents working and all personal activity	pain that keeps me bed ridden	pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

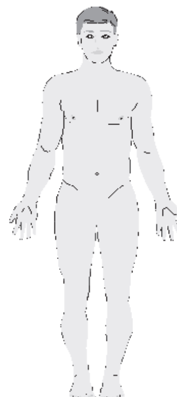
2 ____________________ 4 ____________________

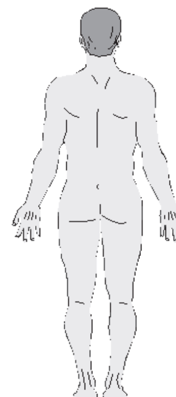
3 ____________________ 5 ____________________

Do you have any other condition other than what brings you here? ☐ yes ☐ no
If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.

N = numbness
T = tingling
P = pain
W = weakness





patient name

3 LIFESTYLES & HABITS

How many hours of television do you watch a day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

Do you usually snack while watching television? ☐ yes ☐ no

How many hours per day do you use a computer at work or home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How often do you exercise? ☐ daily ☐ 3x's/week ☐ 2x's/week ☐ 1x/week ☐ I don't exercise

How long do your exercise work outs last? ☐ >1 hour ☐ 1 hour ☐ 30 minutes ☐ < 30 minutes ☐ NA

What are your exercise activities? (mark all that apply) ☐ I don't exercise

☐ walking ☐ swimming ☐ weight lifting
☐ stretching/flexibility ☐ yoga/Pilates ☐ resistance bands
☐ running/treadmill/rowing/climbing ☐ group exercise classes ☐ other________________

Do you take a multi-vitamin? ☐ yes ☐ no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

Have you ever used tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly ☐ yearly

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	n p c	mother	n p c	father	n p c	brother	n p c	sister
heart problems	n p c	mother	n p c	father	n p c	brother	n p c	sister
kidney problems	n p c	mother	n p c	father	n p c	brother	n p c	sister
cancer	n p c	mother	n p c	father	n p c	brother	n p c	sister
headaches	n p c	mother	n p c	father	n p c	brother	n p c	sister
back pain	n p c	mother	n p c	father	n p c	brother	n p c	sister
obesity	n p c	mother	n p c	father	n p c	brother	n p c	sister
poor conditioning	n p c	mother	n p c	father	n p c	brother	n p c	sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	☐ yes	☐ no	epilepsy	☐ yes	☐ no	low back pain	☐ yes	☐ no	polio	☐ yes	☐ no
anemia	☐ yes	☐ no	goiter	☐ yes	☐ no	measles	☐ yes	☐ no	rheumatic fever	☐ yes	☐ no
appendicitis	☐ yes	☐ no	heart disease	☐ yes	☐ no	mental disorder	☐ yes	☐ no	tuberculosis	☐ yes	☐ no
arthritis	☐ yes	☐ no	HIV positive	☐ yes	☐ no	mumps	☐ yes	☐ no	venereal infection	☐ yes	☐ no
cancer	☐ yes	☐ no	influenza	☐ yes	☐ no	pleurisy	☐ yes	☐ no	whiplash	☐ yes	☐ no
			diabetes	☐ yes	☐ no	pneumonia	☐ yes	☐ no	whooping cough	☐ yes	☐ no

6 INJURIES

patient name

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

7 HOSPITAL / MEDICINE

Have you had breast implant surgery? ☐ yes ☐ no

Have you had knee or hip replacement surgery? ☐ yes ☐ no

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical devices in your body? ☐ yes ☐ no

Mark all of the following procedures as they pertain to you.

vaccinations ☐ yes ☐ no
tonsillectomy ☐ yes ☐ no
gall bladder removal ☐ yes ☐ no
back surgery ☐ yes ☐ no

tubes in ears ☐ yes ☐ no
appendectomy ☐ yes ☐ no
female/male surgery ☐ yes ☐ no
____

rectal surgery ☐ yes ☐ no
sinus surgery ☐ yes ☐ no
hernia surgery ☐ yes ☐ no
thyroid surgery ☐ yes ☐ no
stomach surgery ☐ yes ☐ no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? ☐ yes ☐ no

Were you ever knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no

8 SYSTEM REVIEW

patient name

Mark the following conditions that are **currently** a cause of significant concern for you.

General

☐ consistent fainting	☐ chills	☐ convulsions	☐ depression	☐ dizziness
☐ loss of weight	☐ fatigue	☐ fever	☐ headache	☐ loss of sleep
☐ weight gain	☐ neuralgia	☐ night sweats	☐ wheezing	☐ nervousness

Gastro-Intestinal

☐ constipation	☐ diarrhea	☐ gall bladder problems	☐ hemorrhoids	☐ jaundice
☐ liver problems	☐ nausea	☐ stomach pain	☐ poor appetite	☐ poor digestion
☐ rectal bleeding	☐ vomiting	☐ vomiting blood		

Eye/Ear/Nose/Throat

☐ asthma	☐ crossed eyes	☐ deafness	☐ earache	☐ ear discharge
☐ ear noises	☐ enlarged thyroid	☐ frequent colds	☐ hay fever	☐ hoarseness
☐ nasal obstruction	☐ nose bleeds	☐ pain in eyes	☐ poor vision	☐ sinusitis
☐ sore throat	☐ tonsillitis			

Respiratory

☐ chest pain	☐ chronic cough	☐ difficulty breathing	☐ spitting blood	☐ spitting phlegm

Muscles/Joints/Bones

☐ backache	☐ foot problems	☐ pain bet. shoulders	☐ painful tailbone	☐ stiff neck
☐ spinal curvature	☐ swollen joints	☐ tremors	☐ twitching	☐ weakness

Cardio-Vascular

☐ ankle swelling	☐ high blood pressure	☐ low blood pressure	☐ heart trouble	☐ pain over heart
☐ poor circulation	☐ rapid heart	☐ slow heart	☐ strokes	

Skin or Allergies

☐ bruise easily	☐ dryness	☐ eczema	☐ hives	☐ itching
☐ sensitive skin				

Women

☐ cramps	☐ excessive flow	☐ hot flashes	☐ irregular cycle	☐ painful periods

9 PREGNANCY — WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? ☐ yes ☐ no — On what date did your last period begin?

Do you want to take a pregnancy test now? ☐ yes ☐ no

OFFICE USE ONLY
result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

tubal ligation ☐ yes ☐ no	complete or partial hysterectomy ☐ yes ☐ no	partner had a vasectomy ☐ yes ☐ no
less than 10 days since the start of my last period ☐ yes ☐ no	taking birth control pills ☐ yes ☐ no	

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date