HATFIELD CHIROPRACTIC & REHAB CENTER
CHIROPRACTIC CASE HISTORY

Patient Name ____ Date____________

Date of Birth ______________ Height _________ Weight ___________

Please answer every question. If something does not apply to you, write "N/A".

1. Reason(s) for seeking chiropractic care today:

   PRIMARY Complaint: ____

   SECONDARY Complaint: ____

   ADDITIONAL Complaint: ____

2. Is this due to: ❑Auto accident ❑Work Injury ❑Other ______________________ (**PLEASE NOTIFY FRONT DESK OF ACCIDENT**)

   ❑A worsening long-term problem ❑An interest in: ❑Wellness ❑Other ________________________________

3. When did this occur? ____

4. Describe the pain/discomfort: ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

   ❑ Aching ❑ Burning ❑ Dull ❑ Numbing ❑ Sharp stabbing ❑ Shooting ❑ Throbbing ❑ Tightness

   ❑ Tingling ❑ Other____

5. What have you done to relieve the symptoms? ❑Chiropractic ❑Heat ❑Ice ❑Massage ❑OTC ❑ Rest

   ❑Prescription Medication ❑Acupuncture ❑Homeopathy ❑Physical Therapy ❑Surgery ❑Other

   ____

   …What makes it worse? ❑ Standing ❑ Walking ❑ Movement ↑ ↓ ❑ Lifting ❑ Bending ❑ Sitting

   ❑ Coughing/sneezing ❑ Other ____

6. Have you had this or similar problem before? ❑ No ❑ Yes When?______________________________

7. Have you seen another doctor for this problem? ❑ No ❑ Yes _____________________________________

   Did you receive: ❑ Exam ❑ X-rays ❑ Meds ❑ Other ______________________________________

8. Have you missed work due to this complaint? ❑ No ❑ Yes From date: ________________ To date: _________________

9. Have you seen a chiropractor before? ❑ No ❑ Yes When?_________ Whom?_____________________________

10. PAST HEALTH HISTORY:

    Have you had: ❑Auto accident ❑Bad fall ❑Broken bones ❑Spine/Nerve Disorder ❑Stroke ❑ Other Serious Injury

    ____

    Did you seek professional care? ❑ No ❑ Yes ____

    ____

    Allergies: ____

    Illnesses: ❑Alcoholism ❑Arteriosclerosis ❑Arthritis ❑Asthma ❑Cancer ❑High Cholesterol ❑Diabetes ❑Epilepsy
    ❑Hepatitis ❑High Blood Pressure ❑Heart Disease ❑HIV positive ❑Multiple Sclerosis ❑Osteoporosis
    ❑Sexually Transmitted Disease ❑Tuberculosis ❑Other ____
    ____

    Surgeries: ❑Appendectomy ❑Bypass surgery ❑Cancer ❑Cosmetic surgery ❑Gall Bladder ❑Hysterectomy
    ❑Implant ____________ ❑Pacemaker/Defibrillator ❑Spine: ________________ ❑Tonsillectomy ❑ Other
    ____

    Medications: Are you taking any of the following? ❑ Nerve Pills ❑ Painkillers (including aspirin) ❑ Muscle Relaxers
    ❑Insulin ❑ Blood Thinners ❑ Stimulants ❑Tranquilizers ❑ Anti-Inflammatory ❑Other ___________________

    Health conditions treated in the last 6 months: ____

    ____

Females Only: Are you pregnant? ❑ No ❑ Yes How many weeks? ________ Date of last menstrual period: ____________

11. FAMILY HEALTH HISTORY:

Have any of your immediate family had a major illness or disease? ❑Arthritis ❑Cancer ❑High Blood Pressure ❑High Cholesterol ❑Diabetes ❑Heart Disease ❑Kidney Disease ❑Other________________________________

12. SOCIAL HISTORY:

How often do you exercise?	❑ Daily	❑ Weekly	❑ Sometimes	❑ Never
How often do you drink alcohol?	❑ Daily	❑ Weekly	❑ Sometimes	❑ Never
How often do you smoke?	❑ Daily	❑ Weekly	❑ Sometimes	❑ Never
How often is your caffeine intake?	❑ Daily	❑ Weekly	❑ Sometimes	❑ Never
Do you use recreational drugs?	❑ Yes	❑ No		
How is your diet?	❑ Healthy	❑ Somewhat Healthy	❑ Fast Food	

REVIEW OF SYSTEMS - Please check all that you currently have or have had:

Musculoskeletal	❑ NONE				
❑Osteoporosis	❑Arthritis ❑Gout	❑Scoliosis	❑Neck Pain	❑Back Problems	❑Hip Disorders
❑Knee Injuries	❑Foot/Ankle Pain	❑Shoulder Problems	❑Elbow/Wrist Pain	❑TMJ Issues	❑Poor Posture
Neurological	❑ NONE				
❑Anxiety	❑Depression	❑Headache	❑Dizziness	❑Pins and Needles	❑Numbness
Cardiovascular	❑ NONE				
❑ High Blood Pressure	❑Low Blood Pressure	❑High Cholesterol	❑Poor Circulation	❑Angina	❑Excessive Bruising
Respiratory	❑ NONE				
❑Asthma	❑Apnea	❑Emphysema	❑Hay Fever	❑Shortness of breath	❑ Pneumonia
Digestive	❑ NONE				
❑Anorexia/Bulimia	❑Ulcer	❑Food Sensitivities	❑Heartburn	❑Constipation	❑Diarrhea
Sensory	❑ NONE				
❑ Blurred vision	❑Ringing in ears	❑Hearing Loss	❑Chronic ear infection	❑Loss of smell	❑Loss of taste
Skin	❑ NONE				
❑Skin Cancer	❑Psoriasis	❑Eczema	❑Acne	❑Hair Loss	❑Rash
Endocrine	❑ NONE				
❑Fibroid Issues	❑Immune Disorders	❑Hypoglycemia	❑Frequent Infection	❑Swollen Glands	❑ Low Energy
Genitourinary	❑ NONE				
❑Kidney Stones	❑Infertility	❑Bedwetting	❑ Prostate Issues	❑Erectile dysfunction	❑ PMS Symptoms
Constitutional	❑ NONE				
❑Fainting	❑Low Libido	❑Poor Appetite	❑Fatigue	❑Sudden weight change	❑ Weakness

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient Name ____ Date_________________________________

____
Patient Signature (Parent/Legal Guardian if patient is a minor)

____
Name of Parent/Legal Guardian (print)

____ ________________________________
Relationship to Patient James A. Hatfield, D.C.