HATFIELD CHIROPRACTIC & REHAB CENTER
CHIROPRACTIC CASE HISTORY

Patient Name _____ Date_____

Date of Birth _____ Height _____ Weight _____

Please answer <u>every</u> 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. Does the pain/discomfort radiate/travel to other areas of your body? ❑ No ❑ Yes Where?_____

6. Grade Intensity: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

7. 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 _____

8. Have you had this or similar problem before? ❑ No ❑ Yes When?_____

9. Have you seen another doctor for this problem? ❑ No ❑ Yes _____

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

10. Have you missed work due to this complaint? ❑ No ❑ Yes From date: _____ To date: _____

11. Have you seen a chiropractor before? ❑ No ❑ Yes When?_____ Whom?_____

12. 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: _____

13. 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_____

14. 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.