HATFIELD CHIROPRACTIC & REHAB CENTER
CHIROPRACTIC CASE HISTORY

Patient Name _____ Date_____

Date of Birth _____ Age _____ 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 an accident? (**PLEASE NOTIFY FRONT DESK OF ACCIDENT**):

❑ Auto accident ❑ Work Injury ❑ Other accident: _____

…OR ❑ A worsening long-term problem

❑ An interest in: ❑ Wellness ❑ Other: _____

3. When did this occur? _____

4. Frequency of Pain/Complaint: ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

…Description: ❑ 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 of Pain: (None) 0…..to…..10 (Worst pain imaginable) _____

7. What have you done to relieve the symptoms? ❑ Acupuncture ❑ Chiropractic ❑ Heat

❑ Homeopathy ❑ Ice ❑ Massage ❑ Over-the-counter Medication ❑ Physical Therapy

❑ Prescription Medication ❑ Rest ❑ Surgery ❑ Other: _____

_____

…What makes it worse? ❑ Bending ❑ Coughing/Sneezing ❑ Lifting ❑ Movement ↑ ↓

❑ Sitting ❑ Standing ❑ Walking ❑ Other: _____

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

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

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

10. Have you missed work due to this complaint? ❑ No ❑ Yes

…When? 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 Explain:_____

_____

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: _____

Symptoms: ❑ Blurred vision ❑ Dizziness ❑ Fatigue ❑ Headache ❑ Hip Disorders

❑ Immune Disorders ❑ Kidney Stones ❑ Numbness ❑ Pins and Needles

❑ Ringing in Ears ❑ Scoliosis ❑ Weakness

Are you taking any of the following Medications?

❑ Anti-Inflammatory ❑ Blood Thinners ❑ Insulin ❑ Muscle Relaxers

❑ Nerve Pills ❑ Painkillers (including aspirin) ❑ Stimulants ❑ Tranquilizers

❑ Other: _____

Health conditions treated in the last 6 months: _____

_____

FEMALES: Are you pregnant? ❑ No ❑ Yes How many weeks? ____ Last menstrual period: _____

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 statues.

Patient Name _____ Date_____

_____

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

_____

Name of Parent/Legal Guardian (print)

_____ _____

Relationship to Patient Provider Signature