Your Family Chiropractor

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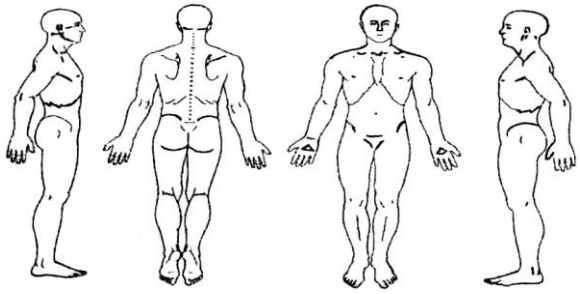
CASE HISTORY

1. Circle the severity (1 = No Pain to 10 = Very Severe Pain) and the Frequency of your pain (% of the day you experience the pain).

(Please list your conditions on the lines below and rate them from top to bottom in the order of severity)

Condition	**Severity** Minimal Severe	**Frequency (% of day)** Occasional Constant
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Please circle the areas on the right figures where you experience pain.



2. When did your symptoms begin? _____
3. Has your condition? Improved ___ Gotten Worse ___ Stayed the same since its onset ___
4. Circle the things that make your problems worse:

   Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting
5. Is there anything you can do to relieve the problems? No ___ Yes ___ Describe: _____

   If No, what have you tried that has not helped? _____
6. Have you been treated for this before? No ___ Yes ___ How long ago? _____
7. What treatment did you receive? _____
8. Results of previous treatment? Good ___ Poor ___ Comments _____
9. Is this condition interfering with Work ___ Sleep ___ Daily Routine ___ Recreation ___
10. Approximate date of last Chiropractic treatment? _____
11. Approximate date of last MD / DO treatment? _____
12. List any other major injuries you have had other than those that might have been mentioned above: _____

_____

13. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ___ No ___. If yes, Please explain _____

I certify that the above information is accurate to the best of my knowledge.

Patient's Signature _____ Date: _____

Guardian's Signature _____ Date: _____

Below is a list of problems that may be important for the Doctor to be aware of. Please check any that you may have had in the past 6 months:

- ❑ Upper Back Pain
- ❑ Midback Pain
- ❑ Low Back Pain
- ❑ Hip Pain
- ❑ Neck Pain
- ❑ Arm /Leg Pain
- ❑ Foot/Hand Pain
- ❑ Knee/Shoulder/Elbow/Wrist Pain
- ❑ Jaw Pain
- ❑ Numbness/Tingling
- ❑ Dizziness/Fainting/Vertigo
- ❑ Sleep Problems
- ❑ Fatigue
- ❑ Headaches/Migraines
- ❑ Stress/Anxiety
- ❑ Allergies
- ❑ Poor Appetite
- ❑ Excessive Thirst
- ❑ Nausea/Vomiting
- ❑ Diarrhea/Constipation
- ❑ Abdominal Pain
- ❑ Urinary Trouble
- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Lung Problems
- ❑ Stroke
- ❑ Ankle Swelling
- ❑ Earaches
- ❑ Menstrual Problems
- ❑ HIV/AIDS
- ❑ Cancer
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Heart Problems
- ❑ Epilepsy

Height: _____ft _____ in
Weight: _____lbs

Doctor Notes

Blood Pressure: _____/_____

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Doctor's Signature: _____