New Patient Case History

Name: ___________________________ Date: _________ Age: _________ Date of Birth: _____________

Begin with symptom that hurts / troubles you the most- then go down the list	**Number each symptom 1= barely hurt 10=the worst**	**When did this symptom begin?**
1. ___________________________________	__________	Date Began: _______________ ☐Constant ☐Comes and Goes
2. ___________________________________	__________	Date Began: _______________ ☐Constant ☐Comes and Goes
3. ___________________________________	__________	Date Began: _______________ ☐Constant ☐Comes and Goes
4. ___________________________________	__________	Date Began: _______________ ☐Constant ☐Comes and Goes
5. ___________________________________	__________	Date Began: _______________ ☐Constant ☐Comes and Goes

OtherSymptoms/Condition: ____

- I feel Pain / Numbness in my: ☐Rt. Arm ☐Lt. Arm ☐Rt. Leg ☐Lt. Leg ☐Headaches ☐N/A
- How far down the arm or leg does the pain go? ____
- In general, is your condition getting: ☐ Better ☐ Worse ☐ Same
- What do you think caused this condition? ☐Automobile ☐Work Date _____________

  ☐ Other: ____
- What activity, position, or time of day seems to make your symptoms worse?

  ____
- What activity, position, or time of day seems to make your symptoms better?

  ____

List all the doctors you have seen for this condition or for *any* condition if it was ***within the last year*:**

	Doctor/Office	**Location**	**Date Last Seen**
1.	________________________________	_________________	____________
2.	________________________________	_________________	____________
3.	________________________________	_________________	____________

- Other than this episode- Have you had a condition like this before? ☐ Yes When: __________ ☐No

  What treatment did you have and by who? ____

  What were the results? ☐ Good ☐ Temporary ☐ didn't help ☐ other: ____________________

- Are you currently taking medications: ☐ Yes ☐ No

  List Medication*: **For What Condition?**

  1. ____
  2. ____
  3. ____
  4. ____
  5. ____

- Do you take Vitamins? ☐ Yes List: ______________________ ☐ No
- Would you be interested in a nutritional program to help facilitate optimal health? ____________
- **CHIROPRACTIC MAY SOMETIMES HELP SOME OF THE FOLLOWING CONDITIONS, OR THEY CAN AFFECT YOUR SPINAL CONDITION AND HEALING TIME. CHECK THOSE THAT APPLY TO YOU.**

Past	Present		Past	Present	
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	Diabetes	☐	☐	Painful Urination
☐	☐	Constipation	☐	☐	Stroke
☐	☐	Diarrhea	☐	☐	Rheumatoid Arthritis
☐	☐	Frequent Urination	☐	☐	Cancer Where: ____________
☐	☐	PMS	☐	☐	Abnormal Weight Loss
☐	☐	Loss of Bladder/Bowel Control	☐	☐	Heart Attack
☐	☐	Headache	☐	☐	Epilepsy
☐	☐	Heartburn/Indigestion	☐	☐	Seizures
☐	☐	Sinus Problems	☐	☐	Dizziness
☐	☐	Prostate Problems	☐	☐	Fainting
☐	☐	Colitis	☐	☐	AIDS/HIV
☐	☐	Menstrual Problems	☐	☐	Permanent Disability Rating _______%
☐	☐	Asthma	☐	☐	Other: ______________

- Do you smoke? ☐ Yes: (How Much) ____________ ☐ No
- Do you drink alcohol? ☐ Yes: (How Much) ____________ ☐ No
- Do you drink coffee/tea/caffeinated drinks? ☐ Yes: (How Much) ____________ ☐ No
- Do you take birth control pills? ☐ Yes ☐ No
- Do you sleep on a ☐ Mattress ☐ Waterbed (<u>We do not recommend waterbeds- ask the doctor</u>)
- What type of pillow do you sleep on? ______________________________________
- As a child, did you have any falls or injuries that could have affected your current spinal condition? ☐ No

  ☐ **Yes** Details: ____

- Do you have any hobbies that strain your spine? ☐ Golf ☐ Bowling ☐ Needlepoint ☐ Horses
- ☐ Reading in Bed ☐ Other: ____
- Have you *ever* had any accidents, falls, auto accidents, etc. that could have contributed to your current condition?
- ☐ **Yes** ☐ No Details: ____
- What surgeries have you had <u>ever</u> to your spine, joints, and bones; or in the <u>*last year* to any other body part?*:</u>

  ____ Date: _________________ Surgeon: __________________

  ____ Date: _________________ Surgeon: __________________

  ____ Date: _________________ Surgeon: __________________

  ____ Date: _________________ Surgeon: __________________

- Is there any chance you could be pregnant? ☐ **Yes** (Date of last period ______) ☐ No ☐ Not Applicable
- Have you ever been to a chiropractor before? ☐ **Yes** ☐No

  If Yes: Clinic/Dr. Name: __________________ Location: ____________________ Date of last visit: ______

  For What Condition: ____

<u>Patient's please use this section for additional notes:</u>

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Patient Signature: ____Date: ________________________________