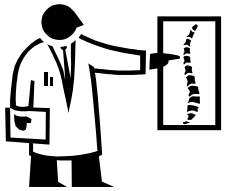
QUICKCHARTS PATIENT CASE HISTORY



Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____

Cell Phone: _____-_____-_____ Email Address: _____

Marital Status: S M W D Referred by: _____

Social Security #: _____-_____-_____ Gender: Male - Female Pregnant? Yes - No

Ever had chiropractic care? No yes When? _____Why? _____ Where?_____

Race:	Ethnicity:
□ American Indian □Nat. Hawaiian/Pacific Islander □Asian □ Other: _____ □African American □Caucasian □Declined	□Declined □Hispanic or Latino □ Other: _____

List any Allergies:

□Animals □Aspirin □Bees □Chocolate □Dairy □Dust □Eggs □Latex □Molds □Penicillin

□Ragweed/Pollen □Rubber □Seasonal Allergies □Shellfish □Soaps □Wheat □X-Ray Dye

□ Other: _____

List any Surgeries:

□Back □Brain □Elbow □Foot □Hip □Knee □Neck □Neurological □Shoulder □Wrist

□Other: ____

List ALL Past Medical History conditions:

□Ankle Pain □Arm Pain □Arthritis □Asthma □Back Pain □Broken Bones □Cancer □Chest Pain

□Depression □Diabetes □Dizziness □Elbow Pain □Epilepsy □Eye/Vision Problems □Fainting □Fatigue

□Foot Pain □Genetic Spinal Condition □Hand Pain □Headaches □Hearing Problems □Hepatitis

□High Blood Pressure □Hip Pain □HIV □Jaw Pain □Joint Stiffness □Knee Pain □Leg Pain

□Menstrual Problems □Mid-Back Pain □Minor Heart Problem □Multiple Sclerosis □Neck Pain

□Neurological Problems □Pacemaker □Parkinson's □Polio □Prostate Problems □Shoulder Pain

□Significant Weight Change □Spinal Cord Injury □Sprain/Strain □Stroke/Heart Attack

□Other: _____

List Type of Medications you are taking:

□Anxiety □Muscle Relaxors □Pain Killers □Insulin □Birth control □Cardiovascular □Allergy □Seizure

□Other: _____

List your Family History:

□Arthritis □ Asthma □Back Pain □ Cancer □ Depression □Diabetes □ Epilepsy □Genetic Spinal Condition

□High Blood Pressure □Heart Problems □Multiple Sclerosis □Neurological Problems □Parkinson's

□Polio □ Prostate Problems □Stroke/Heart Attack □Other: _____

Have you had any auto or other accidents? □No □Yes

Describe:_____

Date of last physical examination: __ _____ Do you smoke? □No □Yes

Do you drink alcohol? □No □Yes - how many per day? _____

Do you drink caffeine? □No □Yes - how many per day? _____

Do you exercise? □No □Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW

Main reason for consulting the office:

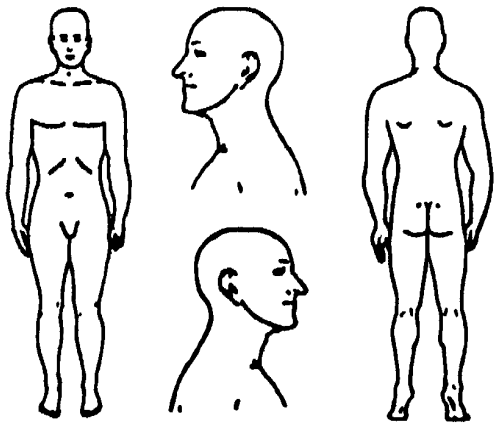
□Become pain free

□Explanation of my condition

□Learn how to care for my condition

□Reduce symptoms

□Resume normal activity level



What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? □GETTING BETTER □GETTING WORSE □NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□Constantly (76-100% of the day) □Frequently (51-75% of the day)

□Occasionally (26-50% of the day) □Intermittently (0-25% of the day)

Describe the nature of your symptoms: □Sharp □Dull □Numb □Burning □Shooting □Tingling □Radiating

Pain □Tightness □Stabbing □Throbbing □Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□1□2 □3 □4 □5 □6 □7 □8 □9 □10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

What activities aggravate your condition (working, exercise, etc)?_____

What makes your pain better (ice, heat, massage, etc)? _____

What is your SECOND complaint? _____Date problem began?_____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? □GETTING BETTER □GETTING WORSE □NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□Constantly (76-100% of the day) □Frequently (51-75% of the day)

□Occasionally (26-50% of the day) □Intermittently (0-25% of the day)

Describe the nature of your symptoms: □Sharp □Dull □Numb □Burning □Shooting □Tingling □Radiating Pain □Tightness □Stabbing □Throbbing □Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

What activities aggravate your condition (working, exercise, etc)?_____

What makes your pain better (ice, heat, massage, etc)? _____

What is your next complaint? _____Date problem began?_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □GETTING BETTER □GETTING WORSE □NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□Constantly (76-100% of the day) □Frequently (51-75% of the day)

□Occasionally (26-50% of the day) □Intermittently (0-25% of the day)

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Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

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