Marketplace Chiropractic
CONFIDENTIAL CASE HISTORY

☐ Dr. Salgueiro ☐ Dr. Carreira

Please fill out this form in its entirety. If you need assistance, please ask the receptionist.

Name: _____ Today's Date: M/D/Y ____/____/ ____
How would you like to be addressed in our office? _____
Address: _____ City:_____ Province:____Postal Code: _____
Home #: (_____)_____Work #:(_____)_____ Cell #:(_____)_____
Biological Sex: □M □F Date of birth: M/D/Y _____/_____/_____ Age: _____
Marital Status: □S □M □D □W □C
Spouse's name: _____ Number of children: _____
Occupation: _____ Employer: _____
Hobbies/Activities/Exercise (how often): _____
Who can we thank for referring you to our office? _____

May we contact you at work? □Y □N What is the best way to contact you? □ Home □ Work □ Cell
May we communicate with you via email? □Y □ N e-mail address: _____
Can we leave messages on your answering machine regarding appointment times and dates? □Y □N
Can we leave messages with other parties regarding appointment times and dates? □Y □N
If yes, with whom _____

Emergency Contact Name: _____ Relationship: _____
Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Reason for Care

Present reason for contacting our clinic:
□ I have a specific problem and want help only with this problem.
□ After my specific problem has been relieved, I am interested in learning how to prevent it in the future.
□ After my specific problem has been relieved, and I have learned how to prevent it, I am interested in learning how to optimize my health.
□ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better. (If you are interested in this option please skip the section titled Current Complaint)

Health History

The human body is designed to be healthy. Throughout your life, events occur which damage your health expression. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. This case history will help us to uncover the layers of damage that have occurred.

Chemical Stress

□Y □N Do you/have you smoked or been exposed to 2nd hand smoke?
If yes, how much? _____ How long? _____
□Y □N Are you/have you been exposed to chemicals at work or elsewhere?
If yes, what chemicals? _____ How long? _____
□Y □N Do you drink alcohol? If yes, how much? _____ How long? _____
□Y □N Are you on any special diets? If yes, explain _____
□Y □N Food / Juice intolerance or allergy? Type: _____

Patient Name: _____ □Dr. Salgueiro □Dr. Carreira

□Y □N Do you take any supplements? What types? _____
□Y □N Do you eat junk food, prepackaged food, or frozen meals? _____
□Y □N Do you drink caffeinated beverages? What? _____ How much? _____
□Y □N Do you drink water? How much? _____
Type? □ Tap □ Bottled □ Filtered □ Distilled □ Other _____
□Y □N Do you take any drugs? (Please include prescription, over the counter, and/or recreational)
_____

Psychosocial/Emotional Stress
□Y □N Do you experience stress in your daily life? If yes, □ work □ home □ other _____
□Y □N Do your experience depression, anxiety or nervousness? _____
□Y □N Have you been abused physically, emotionally, or sexually? _____
□Y □N Have you had any other emotional trauma (e.g. posttraumatic stress)? _____

Physical Stress
□Y □N Did you have a traumatic birth? (e.g. induced labor, forceps, vacuum extraction, forceful pulling, c-section) _____
□Y □N As a child did you ever fall from a significant height? (e.g. bed, change table, tree, monkey bars) _____
□Y □N Have you ever fallen downstairs or slipped on ice? _____
□Y □N Do you/did you participate in any sports? Type _____
□Y □N Do you do any repetitive movements at work? Type _____
□Y □N Do you do a lot of sitting/standing at work? _____
□Y □N Any other trauma or physical stress? _____
□Y □N Do you have restful sleep? How many hours? _____ Age of mattress? _____
Sleeping posture? □ Back □ Stomach □ Side

Current Complaint (skip for wellness patients)

What brought you into the office: _____
When did it start: M/D/Y _____/_____/____ Onset was: □ gradual □ sudden □ associated with an event?
What do you think is the cause of the problem: _____
What makes it worse: _____
What makes it better: _____
What is the quality of the pain/problem: □ Sharp □ Dull □ Achy □ Boring □ Stabbing □ Burning?
□ Throbbing □ Tingling □ Other: _____
Does the pain/problem: □ stay in the same place □ move from one area to another _____
How bad is this problem on a scale of 1-10 with 1 being no problem and 10 being the most severe? ___/10
Pattern of the problem:□Constant □Intermittent □Occasional □Cyclical □___time(s) per day/month/year
Have you ever had this before: _____
Is this problem: □ Getting progressively worse □ Not changing □ Getting better
Does this problem interfere with: □ Sleep □ Work □ Daily Routine □ Other _____?
Effects of problem on body function and daily activities: _____

Please list your family physician or most recent physician: _____
Date of last medical visit: _____
May we contact this physician regarding your care? □Y □N
Physician Contact Information: _____

Patient Name: _____ □Dr. Salgueiro □Dr. Carreira

Have you had previous chiropractic care □Y □N When: _____
Doctor's name: _____ For what reason:_____
Why did you discontinue care? _____
When was your last adjustment? _____ What was your frequency of care? _____

Have you had X-rays or other relevant imaging? □Y □N _____

Other Symptoms/Conditions

Please check all symptoms you have had, even if it doesn't seem related to your current reason for care:

□ (01) Headaches
□ (02) Neck pain
□ (03) Asthma
□ (04) Allergies
□ (05) High blood pressure
□ (06) Heart attack or stroke
□ (07) Cancer
□ (08) Diabetes
□ (09) Chronic Disease _____
□ (10) Surgeries _____
□ (11) Back pain
□ (12) Arthritis
□ (13) Joint Pain _____
□ (14) Numbness/tingling in limbs, where? _____
□ (15) Constipation/diarrhea
□ (16) Dizziness
□ (17) Weight change
□ (18) Vision problems
□ (19) Hospitalizations _____

<u>Females:</u>
□ (20) Painful menstruation
□ (21) Irregular cycles
□ (22) Menopause
□ (23) Are you pregnant
□ (24) Birth control pills
□ (25) Infertility
□ (26) # of miscarriages ____

Family History

□ Diabetes
□ Cancer
□ High blood pressure
□ Heart Disease
□ Digestive issues
□ Stroke

Other health concerns: _____
What do these issues keep you from enjoying? _____

Accident Report

□Y □N Have you been in an accident within the past year? Date: M/D/Y _____/_____/_____
□ work □ auto □ other _____ Briefly explain the accident? _____
□Y □N Did you experience symptoms after the accident? _____
□Y □N Did you require post-accident hospitalization? _____
Where? _____ When? _____ What was done? _____
□Y □N Have you lost days at work? Dates: _____
□Y □N Is insurance involved? _____ Which company? _____
Attorney's name, if any: _____Claim #:_____

□Y □N Have you been in an accident over a year ago? □ work □ auto □ other
Details of the Accident(s)/Date(s): _____
_____

I certify the information given above is true to the best of my knowledge.

Signature _____Date M/D/Y_____/_____/_____

Females Only: Pregnancy Release

I certify, to the best of my knowledge, I am not pregnant and give permission for an x-ray evaluation to be performed. I have been advised that x-ray can be hazardous to an unborn child. First day of last menstrual period: M/D/Y ____/____/____ Signature: _____Date: M/D/Y ____/____/____

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