Chiropractic Case History

Name_____ Sex M F Married___ Single___ Divorced___ Date_____

Address_____ City _____ State_____ Zip_____

Home_____ Work_____ Cell _____ Date of Birth_____

Referred by_____Social Security #_____

Occupation_____ Employer_____

Email _____ I would like to receive email notifications from this office.

Emergency Contact Name/Relationship: _____ Phone Number: _____

1. Primary reason(s) for seeking chiropractic care:

Primary reason (Chief Complaint): _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint:

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

4. Past Health History:

Previous major illnesses, injury or trauma: _____

Allergies: _____

Medications: Reason for taking:

_____ _____

_____ _____

Surgeries/Date: Type of Surgery:

_____ _____

_____ _____

Females – Pregnancies/Date of Delivery: Outcome:

_____ _____

_____ _____

Females - What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family / Cause of parents or siblings death Age at death

_____ _____

_____ _____

6. Social and Occupational History:

Level of Education: O high school O some college O college graduate O post graduate studies

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

_____

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 to provide me with chiropractic care and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ **Date**_____

Functional Rating Index

For use with neck and/or back problems only. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0- No Pain	**1-** Mild Pain	**2-** Moderate Pain	**3-** Severe Pain	**4-** Worst Possible Pain

2. Sleeping

0- Perfect Sleep	**1-** Mildly Disturbed	**2-** Moderately Disturbed	**3-** Greatly Disturbed	**4-** Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0- No Pain No Restrictions	**1-** Mild Pain; No Restrictions	**2-** Moderate Pain; Go Slowly	**3-** Moderate Pain; Some Assistance	**4-** Severe Pain; 100% Assistance

4. Travel (driving, etc.)

0- No Pain on Long Trips	**1-** Mild Pain on Long Trips	**2-** Moderate Pain on Long Trips	**3-** Moderate Pain on Short Trips	**4-** Severe Pain on Short Trips

5. Work

0- Usual Work + Extra	**1-** Usual Work, No Extra	**2-** 50% of Usual Work	**3-** 25% of Usual Work	**4-** Cannot Work

6. Recreation

0- All Activities	**1-** Most Activities	**2-** Some Activities	**3-** Few Activities	**4-** No Activities

7. Frequency of Pain

0- No Pain	**1-** Occasional (25%)	**2-** Intermittent (50%)	**3-** Frequent (75%)	**4-** Constant (100%)

8. Lifting

0- No Pain with Heavy Weight	**1-** Increased Pain with Heavy Weight	**2-** Increased Pain with Moderate Weight	**3-** Increased Pain with Light Weight	**4-** Increased Pain with Any Weight

9. Walking

0- No Pain with Any Distance	**1-** Increased Pain after 1 Mile	**2-** Increased Pain after ½ Mile	**3-** Increased Pain after ¼ Mile	**4-** Increased Pain after Any Distance

10. Standing

0- No Pain with Any Time	**1-** Increased Pain after Several Hours	**2-** Increased Pain after 1 Hour	**3-** Increased Pain after ½ Hour	**4-** Increased Pain after Any Time

Total _____ (/4, X10) = Functional Rating Score _____%

Patient or Guardian Signature _____ **Date**_____

Treating Doctor Signature _____ **Date**_____