

## Confidential Patient Case History

Date \_\_\_\_\_ Name \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Single  Married  Other

Address \_\_\_\_\_ City \_\_\_\_\_ Post Code \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (cell) \_\_\_\_\_ (W) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Are you Pregnant?  Yes  No

No. Children \_\_\_\_\_ Names of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Family Doctor \_\_\_\_\_ Location \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

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## Extended Health Coverage

Health Insurance  Yes  No Company Name \_\_\_\_\_

Coverage per year \_\_\_\_\_ \$ Orthotic Coverage per year \_\_\_\_\_ \$

When does your coverage start? \_\_\_\_\_

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## Previous Chiropractic

What were you being treated for? \_\_\_\_\_

No. treatments received: \_\_\_\_\_ How frequent? \_\_\_\_\_

Results of treatment:  Excellent  Good  Fair  No Help

## Previous Health History

List any previous surgeries/accidents/hospitalizations \_\_\_\_\_  
\_\_\_\_\_

In your whole life, what were your 3 most serious traumas?  
(i.e car accident, falls, sports injury, work injury).

1. \_\_\_\_\_ Date \_\_\_\_\_
2. \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ Date \_\_\_\_\_

## Chief Complaint Record

What is the reason for this visit (ie. specific concern): \_\_\_\_\_

Please explain \_\_\_\_\_

Does this problem interferes with:  Work  Sports  Family Time  Sleep

What is your main reason for wanting to get better? (i.e. exercise, family, live easier)

Have you ever had this before?  Yes  No When? \_\_\_\_\_

When did your present problem begin? \_\_\_\_\_

What caused your present symptoms? \_\_\_\_\_

How often does it occur? \_\_\_\_\_ Rate your pain \_\_\_\_/10

Does your pain feel:  Sharp  Dull  Numb  Tingling  Other \_\_\_\_\_

Does the pain radiate into your arm, leg, other? \_\_\_\_\_

Are the symptoms getting:  Worse  Better  No Change

What makes your symptoms better? \_\_\_\_\_

What makes them worse? \_\_\_\_\_

Have you had treatment for this concern?  Yes  No Type: \_\_\_\_\_

Results of the treatment?  Excellent  Good  Fair  No help

On scale of 1 to 10, rate your commitment to correcting this problem (circle number):

1 2 3 4 5 6 7 8 9 10  
Not committed Somewhat Committed Highly Committed

If not corrected, do you think this problem will get worse in:  1  2  5 years

Do you have any secondary complaints you would like addressed at some point?  
\_\_\_\_\_

List any other medical conditions (ex.diabetes) \_\_\_\_\_

List medications/supplements \_\_\_\_\_

**Rate your current overall health status:**

Poor 1 2 3 4 5 6 7 8 9 10 Excellent!

Where would you like to be? \_\_\_\_\_/10

How long do you think it will take to get there? \_\_\_\_\_

Rate your Stress Level out of \_\_\_\_\_/10

Is your stress caused by:  Work  Home  Family  Other \_\_\_\_\_

Do you exercise?  Yes  No

Do you smoke?  Yes  No  In the Past

Do you drink?  Yes  No  Occasionally

Do you sleep on your:  Stomach  Back  Side

Age of your mattress? \_\_\_\_\_ Type of Pillow you sleep with? \_\_\_\_\_

Do you wear foot orthotics?  Yes  No How old are they? \_\_\_\_\_

**Family History**

Please tick if there is a family history of any of the following:

- Heart Disease  Diabetes  Osteoporosis
- Cancer  High Blood Pressure  Arthritis
- Stroke  Scoliosis  Other \_\_\_\_\_

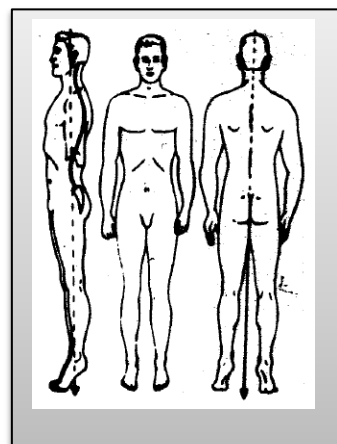
**Patient In-Depth Symptom Survey**

Please check any of the following bodily warning signs you have experienced in the past:

- Headaches  Ringing Ears
- Dizziness  Asthma
- Blurred/Failing Vision  Chest Pain
- Neck Pain/Stiffness  High/Low Blood Pressure
- Tension across Shoulders  Digestive/Stomach Problems
- Numbness/Tingling in Arms/Hands  Heartburn
- Numbness/Tingling in Legs/Feet  Ulcer
- Low Back Pain  Constipation/Diarrhoea
- Hip Pain  Bladder Problems
- Knee Pain  Heart Problems
- Foot Pain  Thyroid Problems
- Leg Pain/Cramps  Immune Problems
- Shin splints  Weight Trouble
- Wrist/Hand Pain  Female Problems
- Arthritis/Swollen Joint  Infertility
- Poor Posture  Sexual Dysfunction
- Other \_\_\_\_\_  Allergies/Infection
- Difficulty Sleeping
- Anxiety/Depression
- Poor Concentration/Memory
- Loss of Energy/Fatigue
- Frequent Colds/Flu

**IMPORTANT!:**

Please mark the area of your pain:



Patient Signature \_\_\_\_\_

Date \_\_\_\_\_