GILMER CHIROPRACTIC

PATIENT CASE HISTORY

Name: ____ DOB: ___ / ___ / ________
Marital Status: ▢ Single ▢ Married ▢ Divorced ▢ Widowed SS# _____ - _____ - ________

Address: ____ Home Phone: ______-______-_______
City: ____ Work Phone: ______-______-_______
State: ____________ Zip: ____________________ Cell Phone: ______-______-_______
Email: _________________________________

Contact Preference: ▢ Home ▢ Work ▢ Cell ▢ Email

Occupation: ____ Gender: ▢ Male ▢ Female
Employer: ____ Height: __________ Weight: __________

1st Emergency Contact: ________________________________ Phone # ______-______-_______
2nd Emergency Contact: ________________________________ Phone # ______-______-_______

List ALL Past Medical History Conditions:

▢ Headaches	▢ Arm Pain	▢ Cancer	▢ Depression
▢ Jaw Pain	▢ Elbow Pain	▢ Diabetes	▢ Neurological Problem
▢ Shoulder Pain	▢ Knee Pain	▢ High BP	▢ Epilepsy
▢ Neck Pain	▢ Leg Pain	▢ Stroke	▢ Fainting
▢ Mid-Back Pain	▢ Foot Pain	▢ Heart Attack	▢ Dizziness
▢ Low Back Pain	▢ Broken Bones	▢ Spinal Cord Injury	▢ Fatigue
▢ Hip Pain	▢ Sprain/Strain	▢ Arthritis	▢ Menstrual Problem

Other conditions not listed above: ____

Circle ALL Surgeries and Note Year

Neck | Back | Spine	Brain | Neurological	Shoulder| Elbow | Wrist	Hip | Knee | Ankle | Foot
Year: ___________	Year: ___________	Year: ___________	Year: ___________

Other Surgeries and Year: ____

Have you had any auto or other incidents? ▢ YES ▢ NO
Describe and note year: ____
____

Have you had in the past year: ▢ Blood Test ▢ Urine analysis ▢ MRI ▢ CT Scan ▢ Ultrasound ▢ X-rays
Reason for the tests ____

Women Only
Month of last period ____________________ Are you pregnant? ▢ YES ▢ NO

PRIMARY complaint? ________________________________ **Date problem began?** ___ / ___ / ________

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

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

How is your condition progressing since it began? ▢ Getting better ▢ Getting worse ▢ Not changing

Rate your pain (0=no pain and 10=worst possible pain) ▢ 0 ▢ 1 ▢ 2 ▢ 3 ▢ 4 ▢ 5 ▢ 6 ▢ 7 ▢ 8 ▢ 9 ▢ 10

Describe the nature of your symptoms: ▢ Burning ▢ Dull ▢ Numb ▢ Radiating Pain ▢ Sharp ▢ Shooting ▢ Soreness ▢ Spasm ▢ Stabbing ▢ Stiffness ▢ Throbbing ▢ Tightness ▢ Tingling ▢ Other: ______________________________

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)

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

(1= no effect and 10= prevents any activities) ▢ 0 ▢ 1 ▢ 2 ▢ 3 ▢ 4 ▢ 5 ▢ 6 ▢ 7 ▢ 8 ▢ 9 ▢ 10

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

Doctor's Notes:

SECONDARY complaints? ________________________________ **Date problem began?** ___ / ___ / ________

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

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

How is your condition progressing since it began? ▢ Getting better ▢ Getting worse ▢ Not changing

Rate your pain (0=no pain and 10=worst possible pain) ▢ 0 ▢ 1 ▢ 2 ▢ 3 ▢ 4 ▢ 5 ▢ 6 ▢ 7 ▢ 8 ▢ 9 ▢ 10

Describe the nature of your symptoms: ▢ Burning ▢ Dull ▢ Numb ▢ Radiating Pain ▢ Sharp ▢ Shooting ▢ Soreness ▢ Spasm ▢ Stabbing ▢ Stiffness ▢ Throbbing ▢ Tightness ▢ Tingling ▢ Other: ______________________________

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

Doctor's Notes:

If you have any other complaints use additional sheets.

By signing, you are confirming the information provided above is accurate and true.

Patient signature ____ **Date**________________

Parent Guardian signature ____ **Date**________________