BENTLEY CHIROPRACTIC
Chiropractic Case History

Name_____ Sex M F Date_____

Mailing Address _____City _____State _____Zip_____

Home Phone (_____) _____Work Phone_____ Date of Birth_____ Age_____

Cell Phone (_____) _____ Carrier_____ Emergency Contact_____ Phone #_____

E-mail address: _____ May we contact you by e-mail Y __ N __

How did you hear about us? _____ Social Security _____

Occupation_____ Employer_____

Marital Status_____ By what name would you like to be addressed? _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

What are your goals for treatment in our office? _____

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? _____

Is there anything you don't do or cannot do because of your condition? _____

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. Primary Care Physician _____
May we share your findings with your other health practitioner(s)? Yes _____ No _____

A. Current or Previous illnesses you've had in your life:_____

_____

B. Previous injury or trauma: _____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

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

5. Family Health History:

Associated health problems of relatives: _____

_____

6. Social and Occupational History:

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

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

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

_____

Do you have insurance you would like us to bill? Yes No

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 of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. I also authorize you to bill my insurance if one has been indicated.

Patient/Parent or Guardian Signature _____ Date _____