Sullivan Chiropractic Case History

Name_____ Sex M F Date_____

Address_____City_____ State_____Zip_____

H. Phone (_____) _____W. Phone_____ Cell Phone _____

Date of Birth_____Age_____Height_____Weight_____

Referred by_____Social Security #_____

Occupation_____ Employer_____

Email address_____ marital status_____

Language preference_____ Emergency contact_____

Special communication needs_____

Have you ever received chiropractic care?_____ If yes, when?_____

Reason for discontinuing care?_____

1. **Primary reason for seeking chiropractic care:**

Primary reason:_____

Secondary reason: _____

2. **Chief complaint:**_____

Location of complaint_____

Complaint began when and how?_____

Please circle the quality of the complaint: dull aching sharp shooting burning throbbing deep nagging other_____

Does this complaint 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? _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing its as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LELVEL OF ACTIVITIES:
O means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 completely able to function 10 totally unable to function

1. FAMILY/HOME RESPONSIBILITES; activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errand, favors for other family members, driving children to school _____

2 .Recreation: hobbies, sports, and other similar leisure time activities _____

3. Social Activity: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dinning out and other social functions. _____

4. Occupation: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. Self Care: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed etc. _____

6. Life Support Activity: basic life supporting behaviors such as eating, sleeping and breathing _____

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

_____

_____

4. Past Health History:

A. 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. 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):_____

_____

Family history of illness:

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. Please be advised that you are responsible for non-covered chiropractic services on a fee for service basis.

Patient signature_____ Date_____

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____