# CONFIDENTIAL CASE HISTORY

**Patient Name:** _____ **Date:** _____

**When did your symptoms start?** _____

**Describe your symptoms and how they began:** _____

_____

**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)

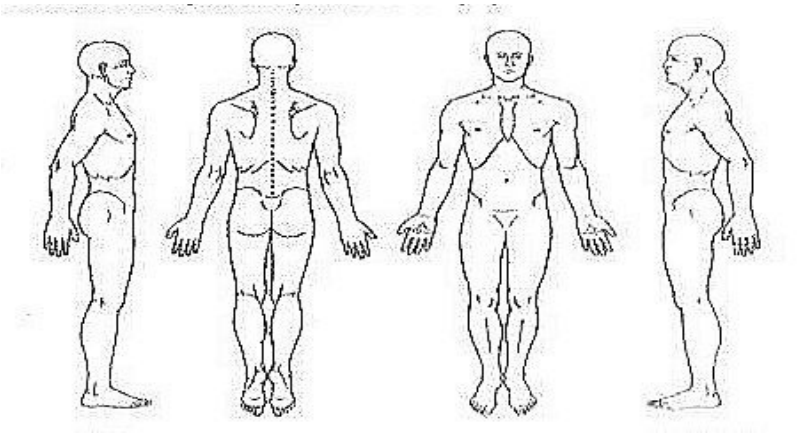
**What describes the nature of your symptoms?**

- ☐ Sharp
- ☐ Dull ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

**How are your symptoms changing?**

- ☐ Getting better
- ☐ Not changing
- ☐ Getting worse

*Indicate in the diagram below where you have pain or other symptoms*



| | | ***None*** | | | | | | | | | | ***unbearable*** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **How bad are your symptoms at their:** | **worst:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | **best:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**How do your symptoms affect your ability to perform daily activities?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| *no complaints* | *mild, forgotten with activity* | | *moderate, interferes with activity* | | *limiting, prevents full activity* | | *intense, preoccupied with seeking relief* | | *severe, no activity possible* | |

**What activities make your symptoms worse?** _____

**What activities make your symptoms better?** _____

**Who have you seen for your current symptoms?**

- ☐ No one
- ☐ Medical Doctor
- ☐ Other
- ☐ Chiropractor
- ☐ Acupuncturist
- ☐ Massage Therapist

**When and what treatment?** _____

**What tests have you had for your symptoms and when were they performed?**

☐ X-Ray: _____ (date) ☐ MRI : _____ (date) ☐ CT Scan: _____ (date) ☐ Other: _____ (date)

**Have you had similar symptoms in the past?** ☐ Yes ☐ No

*If you have received treatment in the past for the same or similar symptoms, who did you see?*

- ☐ This office
- ☐ Medical Doctor
- ☐ Other
- ☐ Chiropractor
- ☐ Acupuncturist
- ☐ Massage Therapist

**What do you hope to get from your treatment?** (Select all that apply):

- ☐ Reduce symptoms
- ☐ Resume/ increase activity
- ☐ Explanation of condition
- ☐ Learn how to care for this on my own
- ☐ How to prevent this

# CONFIDENTIAL CASE HISTORY

**What type of regular exercise do you perform?** ☐ None ☐ Light ☐ Moderate ☐ Strenuous

**What is your height and weight?** Height:_____ Weight: _____

**For each of the conditions listed below, place a check in the *"Past"* column if you have had the condition in the past. If you presently have a condition listed below, place a check in the *"Present"* column.**

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Neck Pain | ☐ | ☐ | Heart Attack | ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Upper Back Pain | ☐ | ☐ | Chest Pains | ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Mid Back Pain | ☐ | ☐ | Stroke | | | |
| ☐ | ☐ | Low Back Pain | ☐ | ☐ | Angina | ☐ | ☐ | Smoking/use of tobacco products |
| ☐ | ☐ | Shoulder Pain | ☐ | ☐ | Kidney Stones | ☐ | ☐ | Allergies |
| ☐ | ☐ | Elbow/Upper Arm Pain | ☐ | ☐ | Kidney Disorders | ☐ | ☐ | Depression |
| ☐ | ☐ | Wrist Pain | ☐ | ☐ | Bladder Infection | ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Painful Urination | ☐ | ☐ | Epilepsy |
| | | | ☐ | ☐ | Loss of Bladder Control | ☐ | ☐ | Dermatitis/Eczema/Rash |
| ☐ | ☐ | Hip/Upper Leg Pain | ☐ | ☐ | Prostate Problems | ☐ | ☐ | HIV/AIDS |
| ☐ | ☐ | Knee/Lower Leg Pain | | | | | | |
| ☐ | ☐ | Ankle/Foot Pain | ☐ | ☐ | Abnormal Weight Gain/Loss | | | |
| | | | ☐ | ☐ | Loss of Appetite | **Females Only:** | | |
| ☐ | ☐ | Jaw Pain | ☐ | ☐ | Abdominal Pain | | | |
| | | | ☐ | ☐ | Ulcer | ☐ | ☐ | Birth Control |
| ☐ | ☐ | Joint Swelling/Stiffness | ☐ | ☐ | Hepatitis | ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Liver/Gall Bladder Disorder | ☐ | ☐ | Pregnancy |
| ☐ | ☐ | Rheumatoid Arthritis | | | | | | |
| | | | ☐ | ☐ | Cancer | | | |
| ☐ | ☐ | General Fatigue | ☐ | ☐ | Tumor | | | |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Asthma | | | |
| ☐ | ☐ | Visual Disturbances | ☐ | ☐ | Chronic Sinusitis | | | |

**Indicate if an immediate family member has had any of the following:**

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ Other: _____

**List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:**

_____

_____

**List all the surgical procedures you have had and the times you have been hospitalized:**

_____

_____

**Authorization**

I certify that I have read, understand and accurately answered the above information to the best of my knowledge. I understand that omitting information or providing inaccurate information can be dangerous to my health.

**Patient signature:** _____ **Date:** _____

**Doctor/Therapist signature:**_____ **Date:** _____