Case History

Name_____ **Date**_____

Main reason for consulting our office? ☐ Temporary Relief ☐ Lasting Correction **Date of Birth**_____ **Age**___

☐Become pain free ☐Explanation of my condition ☐Learn how to care for my condition ☐Reduce symptoms
☐Resume normal activity level ☐ Check here if you want the doctor to select the type of care he/she feels is best for you

MAJOR COMPLAINT

Please describe your major complaint and rate pain from 0-10, 10 being the worst pain and 0 being no pain. (Ex. Sharp pain, numbness, weakness, constant pain)

Headaches: (0-10) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Radiating Pain ☐ Ache ☐ Throbbing

Neck Pain: (0-10) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Radiating Pain ☐ Ache ☐ Throbbing

Upper Back Pain: (0-10) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Radiating Pain ☐ Ache ☐ Throbbing

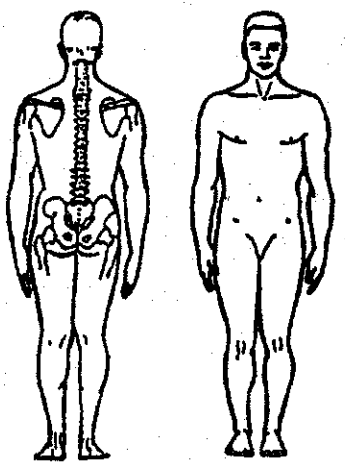
Mid Back Pain: (0-10) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Radiating Pain ☐ Ache ☐ Throbbing

Low Back Pain: (0-10) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Radiating Pain ☐ Ache ☐ Throbbing

Arm or Leg Pain: (0-10) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Radiating Pain ☐ Ache ☐ Throbbing

COMPLETE THESE DIAGRAMS

Please mark the location of your pain on the diagram



What is your major complaint? _____ Date problem began? _____

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

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

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)

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe the nature of your condition. ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Radiating Pain ☐ Ache ☐ Throbbing

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

(0= no effect and 10= no possible activities) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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

What makes your pain better (ice, heat, massage, etc)? _____

Have you seen anyone else for this condition? ☐ Yes ☐ No

If yes, which of the following? ☐ Chiropractor ☐ MD ☐ Physical Therapist ☐ Other_____

Whom _____ When _____

Were X-Rays Taken? Yes No If Yes When? _____

What treatment have you received for this condition? _____

Results from previous treatment? ☐ Good ☐ Poor; comments:_____

New Patients please continue to back side

Has your condition? ☐ Improved ☐ Gotten Worse ☐ Stayed the same since its onset

What area of your life does this condition affect? ☐ Home ☐ Occupational ☐ Recreational ☐ Rest and Sleep

☐ Other_____ ☐ Hobbies_____

Have you been treated by a Chiropractor before? ☐ Yes ☐ No If yes When?_____

What adjusting method did your last Chiropractor use? ☐ Manual ☐ Instrument ☐ Not sure ☐ Other _____

Is there any medical diagnosis of your current complaint? _____

Were you referred by a physician to this clinic? ☐ Yes ☐ No If yes, whom? _____

Who is your medical doctor? _____Date of last visit?_____

Do you grant the BAC Clinic permission to share any abnormal findings with your Medical Doctor? Yes No

Are there any past injuries or traumas not including what you are coming into the office for today? (Ex.sports injury, slip and fall, injured on the job etc.) ☐ Yes ☐ No If yes, please explain below:

Describe the accident, injury or condition_____

_____

How long ago_____

Before this injury had you ever been in an automobile accident? ☐ Yes ☐ No If yes, please explain_____

_____

_____

Have you had any past surgeries/operations? ☐ Yes ☐ No If yes, please explain

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Wrist ☐ Shoulder ☐ Other_____

_____

Are you taking any medications? ☐ Yes ☐ No (If yes, please check appropriate box(es))

☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Diuretics

☐ Tranquilizers ☐ Insulin ☐ Birth Control Pills ☐ Other_____

Please List: _____

_____

If you are female, is there a chance that you may be pregnant? ☐ Yes ☐ No ☐ Not Applicable

Fees are payable at the time x-rays, examinations and treatments are received, unless other arrangements are made in advance. X-ray copies are available upon request.

Patient's signature_____

Doctor's Notes:_____

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