

CASE HISTORY FORM

Welcome to Chapman Chiropractic Center. We look forward to being part of your healthcare team. To help us serve you better, please provide the following information.

Personal Information

Name: _____ **DOB:** ____/____/____ **Gender** (circle): M F
 (Legal First) (Middle Initial) (Legal Last)

Address:

 (Street)

 (City)

 (State)

 (Zip)

Home Phone Number: _____ **Cell Number:** _____ **Work Number:** _____
Is it ok to call you at work? Yes No

Relationship Status (circle one): Married/Single/Widowed/Divorced/Other

Social Security #: _____ - _____ - _____

Email: _____

Employer Name: _____

Work Status (circle one): Employed/Student/Retired/Homemaker/Unemployed

Type of Work/Work Duties: _____

Who may we thank for referring you to our office? Family Member: _____

Friend/Coworker: _____

Phone Book Web Search Drive By/Live Close Other: _____

Past Health Information

Previous (Event and Approximate Date): Motor Vehicle Accidents _____

Childhood Traumas _____ Childhood Illnesses _____

Sports Injuries _____ Major Injuries/Falls _____

Work Injuries _____ Emotional Traumas _____

Broken Bones _____ Cancer _____

Stroke _____ Major Strains/Sprains: _____

Hospitalizations _____ Other: _____

Major Surgeries/Operations: Appendectomy Tonsillectomy Gall Bladder C-Section Hernia Repair Hysterectomy
 Pace Maker Back/Neck Surgery _____ Joints Replaced _____ Other: _____

Family Health History (List Relationship): Diabetes _____ Cancer _____
 Heart Disease _____ Stroke _____ Thyroid _____
 Psychiatric _____ Other: _____

Have You Had Previous Chiropractic Care? () No () Yes, please provide: Dr.'s Name: _____

Clinic Name/Location _____ Date of Last Visit _____ Reason for Visit: _____

Family/Primary Physician: Dr.'s Name: _____ Date of Last Visit: _____

Clinic Name/Location _____ Reason for Visit: _____

Vitamin/Supplement/Medication Name (Please Provide a list if available)	Amount Taken (mg)	How Long I've Been Taking It	Reason for Vitamin/Supplement/Medication

Lifestyle	Often	Occasionally	Never	In the Past	Rate the following as Poor, Good, Excellent
Smoke/use tobacco?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diet: Poor Good Excellent
Drink alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercise: Poor Good Excellent
Play adult sports?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sleep: Poor Good Excellent
Drink caffeine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Water Intake: Poor Good Excellent
Computer/TV use?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

On a scale of 1 – 10, please describe your stress level over the past several months: (1 = None/10 = Extreme)

Occupational Stress _____ **Personal Stress** _____

Have you had trouble with any of the following?

Cardiovascular	Current	Recent	No
Poor Circulation	0	0	0
High Blood Pressure	0	0	0
Low Blood Pressure	0	0	0
Aortic Aneurysm	0	0	0
Heart Disease	0	0	0
Vascular Disease	0	0	0
Heart Attack	0	0	0
Chest Pain	0	0	0
Irregular Heartbeat	0	0	0
Swelling of Legs/Ankles	0	0	0
Genitourinary	Current	Recent	No
Kidney Disease	0	0	0
Lower Side Pain	0	0	0
Burning with Urination	0	0	0
Frequent Urination	0	0	0
Blood in Urine	0	0	0
Kidney Stone	0	0	0
Incontinence	0	0	0
Urinary Infection	0	0	0
Hematologic/Lymphatic	Current	Recent	No
Hepatitis	0	0	0
Blood Clots	0	0	0
Easy Bruising	0	0	0
Easy Bleeding	0	0	0
Fevers/Chills/Sweats	0	0	0
Respiratory	Current	Recent	No
Asthma	0	0	0
Shortness of Breath	0	0	0
Emphysema	0	0	0
Bronchitis	0	0	0
Cold/Flu	0	0	0
Persistent Cough	0	0	0
Ears/Nose/Throat	Current	Recent	No
Hearing Loss	0	0	0
Sinus Infection	0	0	0
Sore Throat	0	0	0
Difficult Swallowing	0	0	0
Bleeding Gums	0	0	0
Frequent Ear Infections	0	0	0
Eyes	Current	Recent	No
Glaucoma	0	0	0
Cataracts	0	0	0
Double Vision	0	0	0
Blurred Vision	0	0	0
Integumentary	Current	Recent	No
Skin Lesions/Rashes	0	0	0
Eczema	0	0	0
Psoriasis	0	0	0
Constitutional	Current	Recent	No
Weight Loss/Gain: _____ lbs.	0	0	0
Unexplained Fatigue	0	0	0
Difficulty Sleeping	0	0	0
Psychiatric	Current	Recent	No
Depression	0	0	0
Nervousness/Anxiety	0	0	0
Unusual Stress	0	0	0

Other: _____

Immunologic	Current	Recent	No
Immune Disorder	0	0	0
HIV/AIDS	0	0	0
Seasonal Allergies	0	0	0
Gastrointestinal	Current	Recent	No
Gallbladder Problems	0	0	0
Bowel Problems	0	0	0
Constipation	0	0	0
Diarrhea	0	0	0
Liver Problems	0	0	0
Ulcers	0	0	0
Nausea/Vomiting	0	0	0
Bloody Stools	0	0	0
Poor Appetite	0	0	0
Heartburn	0	0	0
Food Allergies: _____	0	0	0
Musculoskeletal	Current	Recent	No
Arthritis	0	0	0
Joint Stiffness	0	0	0
Muscle Weakness	0	0	0
Difficulty Walking	0	0	0
Osteoporosis/Bone Loss	0	0	0
Neck Pain	0	0	0
Back Pain	0	0	0
Jaw/TMJ Problems	0	0	0
Hip Pain/Stiffness	0	0	0
Scoliosis	0	0	0
Endocrine	Current	Recent	No
Hypothyroidism	0	0	0
Hyperthyroidism	0	0	0
Excessive Thirst	0	0	0
Hot Flashes	0	0	0
Neurological	Current	Recent	No
Dizziness/Vertigo	0	0	0
Seizures	0	0	0
Tremors	0	0	0
Head Injury	0	0	0
Headaches/Migraines	0	0	0
Fainting	0	0	0
ADHD/ADD/Autism	0	0	0
Pinched Nerves	0	0	0
Carpal Tunnel	0	0	0
Tingling/Numbness	0	0	0
in arms/hands/fingers/legs/feet/toes			
Reproductive	Current	Recent	No
Menstrual Pain	0	0	0
Menstrual Irregularity	0	0	0
Fertility Problems	0	0	0
Prostate Dysfunction	0	0	0
Sexual Dysfunction	0	0	0
Endometriosis	0	0	0
Polycystic Ovarian Syndrome	0	0	0
FEMALES ONLY:			
Date of your last period? _____			
Are you or is there a possibility that you are pregnant?			
0 Yes 0 No			

Are you trying to become pregnant? Yes No

Please tell us what brought you into our office today: (check one)

- Wellness Care: please skip to the next page.
- Health challenge/symptom: please provide details below
- Injury: please provide details below

HEALTH CHALLENGE/SYMP TOM #1

Please describe your primary health challenge/symptom: _____

What accidents/events/activities do you think are the cause? _____

When did it start? # Days ago _____ # Weeks ago _____ # Months ago _____ # Years ago _____

What makes it better? _____

What makes it worse? _____

How would you describe the amount of time that you experience the health challenge/symptom? Please circle one.

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Achy/ Burning/ Cramping/ Dull/ Numbness/ Sharp/ Shooting/ Stabbing/ Stiffness/ Swelling/ Throbbing/ Tingling

Location of any numbness/tingling/radiating symptoms: _____

Severity of Discomfort (0 = No Discomfort, 10 = Severe Discomfort): 0 1 2 3 4 5 6 7 8 9 10

List any daily activities/functions that are limited or difficult because of the symptom.

Please be as specific as you can. (i.e.: concentration, working, sleeping, sitting, standing, bending, lifting)

HEALTH CHALLENGE/SYMPTOM #2 (If Applicable):

Please describe your secondary health challenge/symptom: _____

What accidents/events/activities do you think are the cause? _____

When did it start? # Days ago _____ # Weeks ago _____ # Months ago _____ # Years ago _____

What makes it better? _____

What makes it worse? _____

How would you describe the amount of time that you experience the health challenge/symptom? Please circle one.

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Type of pain: Achy/ Burning/ Cramping/ Dull/ Numbness/ Sharp/ Shooting/ Stabbing/ Stiffness/ Swelling/ Throbbing/ Tingling

Location of any numbness/tingling/radiating symptoms: _____

Severity of Discomfort (0 = No Discomfort, 10 = Severe Discomfort): 0 1 2 3 4 5 6 7 8 9 10

List any daily activities/functions that are limited or difficult because of the symptom.

Please be as specific as you can. (i.e.: concentration, working, sleeping, sitting, standing, bending, lifting)

Please list/circle any other health challenges/symptoms not listed above:

JAW/ TMJ (L/R) RIB (L/R) SHOULDER (L/R) ELBOW (L/R) WRIST (L/R) HIP (L/R) KNEE (L/R) ANKLE (L/R)

Have you been evaluated by another healthcare professional for any of the above-listed health challenges/symptoms?

() No () Yes If yes, please provide the following information:

Name: _____

Clinic/Hospital Name and Location _____

Reason for Visit: _____ Date of Last Visit: _____

Name: _____

Clinic/Hospital Name and Location _____

Reason for Visit: _____ Date of Last Visit: _____

Have you had any MRI/CT or XRAY Studies performed?

() No () Yes If yes, please provide the following information:

Date: _____

Clinic/Hospital Name and Location: _____

Date: _____

Clinic/Hospital Name and Location: _____

OVERALL HEALTH ASSESSMENT:

1) How would you rate your current health status: (circle one) Excellent Good Average Poor

2) Where would you like your health to be? (circle one) Excellent Good Average Poor

3) Are any of the health challenges/symptoms you described preventing you from doing any activities that you need to do or want to do? Please explain in detail:

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE