QUICKCHARTS PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

List any **Allergies**:

z Animals z Aspirin z Bees z Chocolate z Dairy z Dust z Eggsz Latex z Molds z Penicillin z Ragweed/ Pollen

z Rubber z Seasonal Allergies z Shellfish z Soaps z Wheat z X-Ray Dye z Other: _____

List any **Surgeries**:

z Back z Brain z Elbow z Foot z Hip z Knee z Neck z Neurological z Shoulder z Wrist z Other: _____

List **ALL Past Medical History** conditions:

z Ankle Pain z Arm Pain z Arthritis z Asthma z Back Pain z Broken Bones z Cancer z Chest Pain z Depression

z Diabetes z Dizziness z Elbow Pain z Epilepsy z Eye/Vision Problems z Fainting z Fatigue z Foot Pain

z Genetic Spinal Condition z Hand Pain z Headaches z Hearing Problems z Hepatitis z High Blood Pressure

z Hip Pain z HIV z Jaw Pain z Joint Stiffness z Knee Pain z Leg Pain z Menstrual Problems z Mid-Back Pain

z Minor Heart Problem z Multiple Sclerosis z Neck Pain z Neurological Problems z Pacemaker z Parkinson's

z Polio z Prostate Problems z Shoulder Pain z Significant Weight Change z Spinal Cord Injury z Sprain/ Strain

z Stroke/Heart Attack z Other: _____

List Type of **Medications** you are taking:

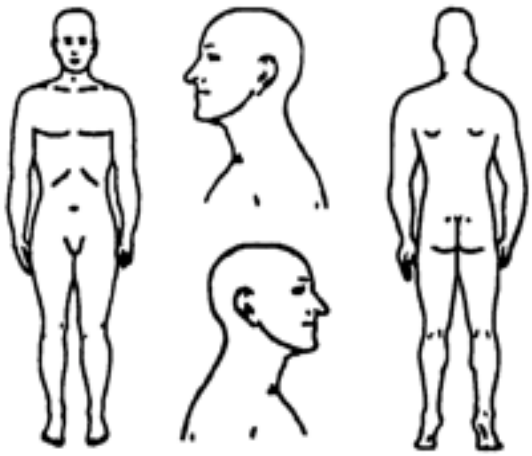
z Anxiety z Muscle Relaxors z Pain Killers z Insulin z Birth control z Cardiovascular z Allergy z Seizure
z Other: _____

List your **Family History**:
z Arthritis z Asthma z Back Pain z Cancer z Depression z Diabetes z Epilepsy z Genetic Spinal Condition
z High Blood Pressure z Heart Problems z Multiple Sclerosis z Neurological Problems z Parkinson's z Polio
z Prostate Problems z Stroke/Heart Attack z Other:
_____

Have you had any auto or other accidents? z No zYes
Describe: _____-
_____

Date of last physical examination: _____ Do you smoke? z No zYes
Do you drink alcohol? z No zYes - how many per day? _____
Do you drink caffeine? z No zYes - how many per day? _____
Do you exercise? z No zYes (what forms and how often):
_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- z Become pain free
- z Explanation of my condition
- z Learn how to care for my condition
- z Reduce symptoms
- z Resume normal activity level

What is your major complaint? _____Date problem began?
_____

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

_____

How is your condition changing? z GETTING BETTER z GETTING WORSE z NOT CHANGING

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

How often do you experience your symptoms?

z Constantly (76-100% of the day) z Frequently (51-75% of the day)

z Occasionally (26-50% of the day) z Intermittently (0-25% of the day)

Describe the nature of your symptoms: z Sharp z Dull z Numb z Burning z Shooting z Tingling z Radiating Pain

z Tightness z Stabbing z Throbbing z Other:

_____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

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

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

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

_____

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

_____

What is your SECOND complaint? _____Date problem began?

_____

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

_____

How is your condition changing? z GETTING BETTER z GETTING WORSE z NOT CHANGING

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

How often do you experience your symptoms?

z Constantly (76-100% of the day) z Frequently (51-75% of the day)

z Occasionally (26-50% of the day) z Intermittently (0-25% of the day)

Describe the nature of your symptoms: z Sharp z Dull z Numb z Burning z Shooting z Tingling z Radiating Pain

z Tightness z Stabbing z Throbbing z Other:

_____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

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

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

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

_____

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

_____

What is your major complaint? _____Date problem began?

_____

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

_____

How is your condition changing? z GETTING BETTER z GETTING WORSE z NOT CHANGING

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

How often do you experience your symptoms?

z Constantly (76-100% of the day) z Frequently (51-75% of the day)

z Occasionally (26-50% of the day) z Intermittently (0-25% of the day)

Describe the nature of your symptoms: z Sharp z Dull z Numb z Burning z Shooting z Tingling z Radiating Pain

z Tightness z Stabbing z Throbbing z Other:

_____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

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

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

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

_____

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

_____

Have you ever had chiropractic care? ! No ! yes

When? _____Why? _____

Where? _____

Were X-rays taken? ! No ! Yes

When was your last adjustment? _____