

# New Patient Case History

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Begin with symptom that hurts / troubles you the most- then go down the list

Number each symptom  
1= barely hurt 10=the worst

When did this symptom begin?

|          |       |  |
|----------|-------|--|
| 1. _____ | _____ | Date Began: _____<br><input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes |
| 2. _____ | _____ | Date Began: _____<br><input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes |
| 3. _____ | _____ | Date Began: _____<br><input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes |
| 4. _____ | _____ | Date Began: _____<br><input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes |
| 5. _____ | _____ | Date Began: _____<br><input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes |

OtherSymptoms/Condition: \_\_\_\_\_

▪ I feel Pain / Numbness in my:  Rt. Arm  Lt. Arm  Rt. Leg  Lt. Leg  Headaches  N/A

▪ How far down the arm or leg does the pain go? \_\_\_\_\_

▪ In general, is your condition getting:  Better  Worse  Same

▪ What do you think caused this condition?  Automobile  Work Date \_\_\_\_\_

Other: \_\_\_\_\_

▪ What activity, position, or time of day seems to make your symptoms worse?  
\_\_\_\_\_

▪ What activity, position, or time of day seems to make your symptoms better?  
\_\_\_\_\_

List all the doctors you have seen for this condition or for *any* condition if it was **within the last year:**

| Doctor/Office | Location | Date Last Seen |
|---------------|----------|----------------|
| 1. _____      | _____    | _____          |
| 2. _____      | _____    | _____          |
| 3. _____      | _____    | _____          |

- Other than this episode- Have you had a condition like this before?  Yes When: \_\_\_\_\_  No

What treatment did you have and by who? \_\_\_\_\_

What were the results?  Good  Temporary  didn't help  other: \_\_\_\_\_

- Are you currently taking medications:  Yes  No

**List Medication\*:**

**For What Condition?**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- Do you take Vitamins?  Yes List: \_\_\_\_\_  No
- Would you be interested in a nutritional program to help facilitate optimal health? \_\_\_\_\_

**CHIROPRACTIC MAY SOMETIMES HELP SOME OF THE FOLLOWING CONDITIONS, OR THEY CAN AFFECT YOUR SPINAL CONDITION AND HEALING TIME. CHECK THOSE THAT APPLY TO YOU.**

| <b>Past</b>              | <b>Present</b>           |                               | <b>Past</b>              | <b>Present</b>           |                                    |
|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure           | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                      | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation                  | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea                      | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination            | <input type="checkbox"/> | <input type="checkbox"/> | Cancer Where: _____                |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS                           | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Loss               |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder/Bowel Control | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache                      | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion         | <input type="checkbox"/> | <input type="checkbox"/> | Seizures                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems                | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems             | <input type="checkbox"/> | <input type="checkbox"/> | Fainting                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis                       | <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Problems            | <input type="checkbox"/> | <input type="checkbox"/> | Permanent Disability Rating _____% |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                        | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                       |

- Do you smoke?  Yes: (How Much) \_\_\_\_\_  No
- Do you drink alcohol?  Yes: (How Much) \_\_\_\_\_  No
- Do you drink coffee/tea/caffeinated drinks?  Yes: (How Much) \_\_\_\_\_  No
- Do you take birth control pills?  Yes  No
- Do you sleep on a  Mattress  Waterbed (We do not recommend waterbeds- ask the doctor)

What type of pillow do you sleep on? \_\_\_\_\_

- As a child, did you have any falls or injuries that could have affected your current spinal condition?  No

Yes Details: \_\_\_\_\_

