CHIROPRACTIC CARE CASE HISTORY

NAME: ______________________________ DATE: __________

ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: ________

TELEPHONE (HOME): ____________ (MOBILE): ____________ E-MAIL: ______________

SOCIAL SECURITY: ____________ DRIVER LIC#: ______________

AGE: ________ BIRTH DATE: ________ SEX: __ MARITAL STATUS: M S W D NUMBER OF CHILDREN: _____

HEIGHT: ______ WEIGHT: _____ REFERRED BY: ______________________________

OCCUPATION: ____________ EMPLOYER: ______________ YEARS EMPLOYED: ________

EMPLOYERS ADDRESS: ______________________ CITY: ______________

STATE: _______ ZIP: ________ EMPLOYER'S PHONE: ______________ EXT: ________

SPOUSES NAME: ______________________ OCCUPATION EMPLOYER: ____________

WHAT IS YOUR MAJOR COMPLAINT? ______________________________

HOW LONG HAVE YOU HAD THIS CONDITION? ____________

HAVE YOU HAS THIS OR A SIMILAR CONDITION IN THE PAST? ____________

WHAT AGGRAVATES YOUR CONDITION? ______________

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES ☐ NO ☐ CONSTANT ☐ COMES AND GOES ☐

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? ______________________

LIST SURGICAL OPERATIONS: ______________________________

ARE YOU TAKING ANY MEDICATIONS? ______ WHAT KIND? ______________________

OTHER DOCTORS SEEN FOR THIS CONDITION: MD ☐ DC ☐ DO ☐ DDS ☐

DOCTOR'S NAME: ______________________ DIAGNOSIS: ______________________

X-RAYS OR OTHER TAKEN? __________ WHEN: __________ RESULTS: ______________

PHYSIOTHERAPY: _____ LENGTH OF TIME UNDER CARE: ______________ WERE YOU OFF WORK? ______

IF SO, HOW LONG: ______________________________

INSURANCE INFORMATION

ARE YOU COVERED BY MEDICARE? YES ☐ NO ☐ MEDICARE #: ______ STATE INSURANCE AID? YES ☐ NO ☐

DO YOU HAVE ANY GROUP, UNION OR PERSONAL HEALTH AND ACCIDENT INSURANCE? YES ☐ NO ☐

NAME OF INSURANCE COMPANY: ______________ POLICY #: __________ GROUP #: __________

ADDRESS: ______________________ CITY: ______________ STATE: ______ ZIP: ________

PHONE: ______________ AGENT: ______________ CLAIM #: ______________

I clearly understand and agree that all of the services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I ALSO AGREE TO PAY AND COLLECTION FEES ASSOCIATED WITH MY BILL INCURRED AT THIS OFFICE.

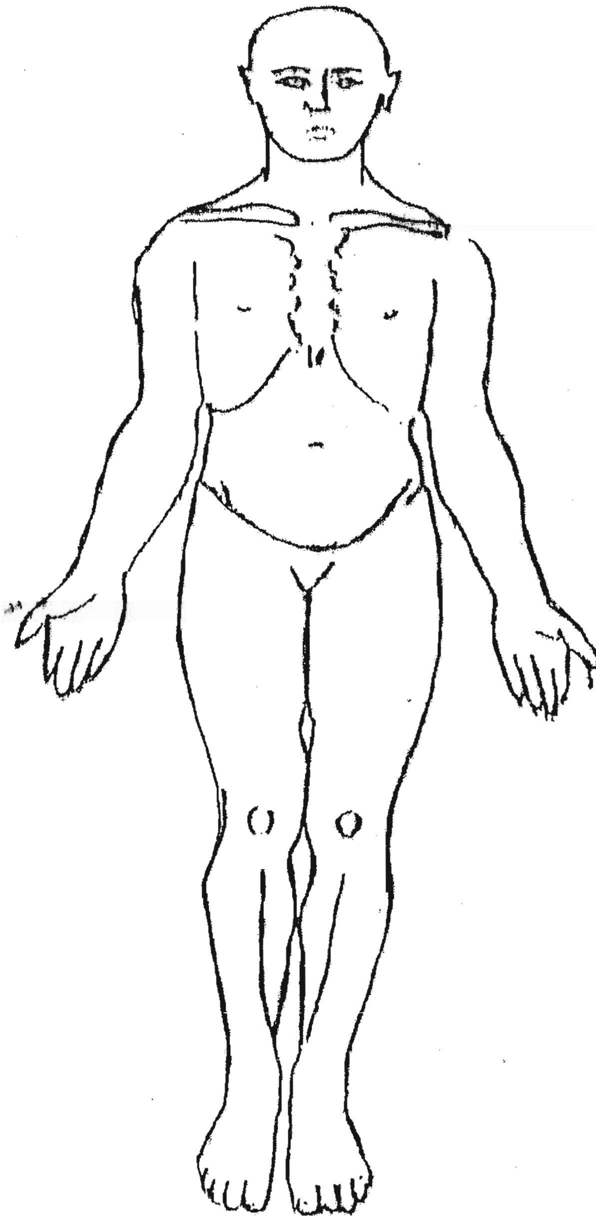
Patient's Signature: ______________________________ Date: ____________

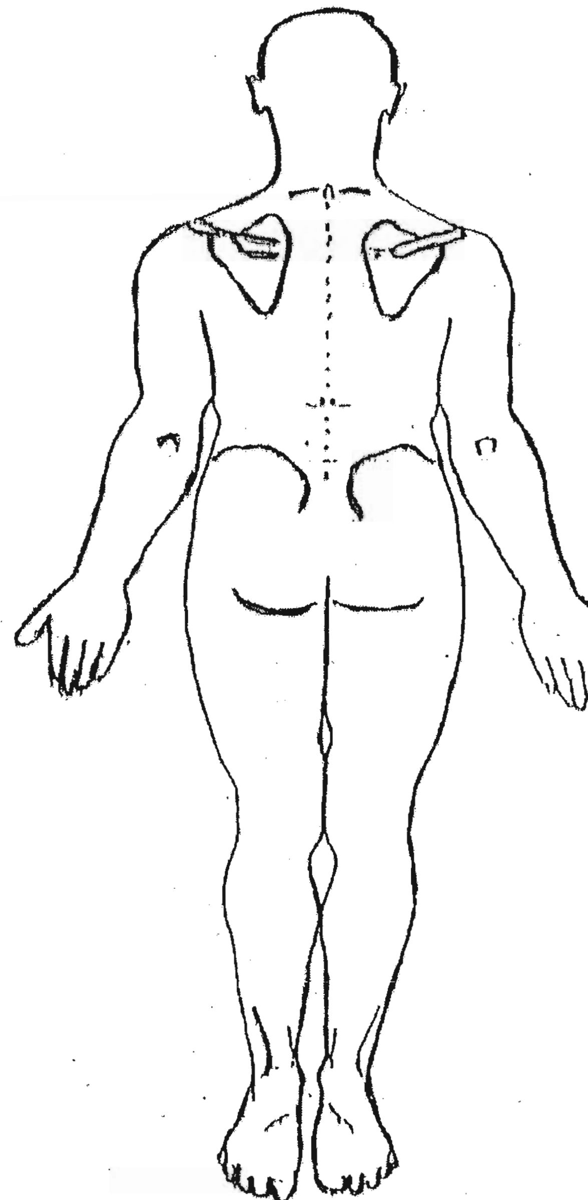
Carlsbad Chiropractic

Name______________________________ Date ______________________

In the drawing below please indicate where you are experiencing pain by drawing in the letter abbreviation (s) on the diagram that most accurately reflects the type of discomfort that you have experiencing.

Numbness = N	Tingling = T	Dull Pain = D
Sharp pain = P	Burning = B	Stiffness = S





SYMPTOM SURVEY

NAME ______________________ DATE ______________

1. GENERAL SYMPTOMS: (Circle as many as apply)

A) Nervousness B) Irritability C) Fatigue D) Depression
E) Loss of Sleep F) Tension G) PMS H) Jaw Pain

2. HEAD: (Circle as many as apply)

A) Headache 1) Mild 2) Moderate 3) Severe
How often: (1 2 3 4 5 6 7) Per (Day/Wk/ Mo)
Are they: 1) Sharp 2) Dull
Are they: 1) Constant 2) Intermittent
Where Located: 1) Back of Head 2) Forehead 3) Temple 4) Right Side 5) Left Side 6) Behind Eyes
B) Light Headed C) Memory Loss D) Fainting
E) Blurred Vision F) Double Vision G) Sensitivity to Light
H) Loss of Balance I) Hearing Loss J) Ringing in Ears

3. NECK: (Circle as many as apply)

A) Pain 1) Left Side 2) Right Side 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain Increased by: 1) Forward Movement 2) Backward Movement 3) Rotate Head Rt 4) Rotate Head Lt 5) Bend Neck Rt 6) Bend Neck Lt
B) Stiffness C) Muscle Spasm D) Grinding/Grating Sounds

4. SHOULDERS: (Circle as many as apply)

A) Pain in Joint	1) Left	2) Right	3) Both
B) Pain Across Shoulder	1) Left	2) Right	3) Both
C) Limitation of Movement	1) Left	2) Right	3) Both
D) Tension	1) Left	2) Right	3) Both

5. ARMS: (Circle as many as apply)

A) Pain in Upper Arm	1) Left	2) Right	3) Both
B) Pain In Elbow	1) Left	2) Right	3) Both
C) Pain in Forearm	1) Left	2) Right	3) Both
D) Pins & Needles (Arm)	1) Left	2) Right	3) Both
E) Pins & Needles (Forearm)	1) Left	2) Right	3) Both
F) Numbness in Arm	1) Left	2) Right	3) Both
G) Numbness in Forearm	1) Left	2) Right	3) Both

6. HANDS: (Circle as many as apply)

A) Pain in Wrist	1) Left	2) Right	3) Both
B) Pain in Hand	1) Left	2) Right	3) Both
C) Pins & Needles (Hand)	1) Left	2) Right	3) Both
D) Numbness (Hand)	1) Left	2) Right	3) Both

7. MIDBACK: (Circle as many as apply)

A) Pain	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Sever
Pain Type	1) Sharp/Stabbing	2) Dull Ache	
B) Muscle Spasm	1) Left	2) Right	3) Both

8. CHEST: (Circle as many as apply)

A) Deep Chest Pain	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Sever
B) Pain Around Ribs	1) Left	2) Right	3) Both
C) Shortness of Breath			
D) Irregular Heartbeat			

9. ABDOMINAL SYMPTOMS: (Circle as many as apply)

A) Pain 1) Mild 2) Moderate 3) Sever
B) Nervous Stomach C) Heartburn D) Gas E) Constipatio
F) Diarrhea G) Nausea H) Indigestion I) Loss of Appetit

10. LOWBACK: (Circle as many as apply)

A) Upper Lumbar Pain	1) Left	2) Right	3) Both
B) Lower Lumbar Pain	1) Left	2) Right	3) Both
C) Sacroiliac Pain	1) Left	2) Right	3) Both
D) Muscle Spasm	1) Left	2) Right	3) Both
Low Back Pain Level	1) Mild	2) Moderate	3) Sever

11. HIPS AND LEGS: (Circle as many as apply)

A) Pain in Buttocks	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Sever
B) Pain in Hip Joint	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Sever
C) Pain Down Leg	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
Pain Radiates to	1) Knee	2) Calf	3) Foot
D) Numbness Down Leg	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
E) Pins & Needles (Legs)	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
F) Knee Pain Leg	1) Left	2) Right	3) Both
G) Leg Cramps	1) Left	2) Right	3) Both

12. FEET: (Circle as many as apply)

A) Ankle Pain	1) Left	2) Right	3) Both
B) Swollen Ankle	1) Left	2) Right	3) Both
C) Foot Pain	1) Left	2) Right	3) Both
D) Numbness of Feet	1) Left	2) Right	3) Both
E) Swollen Feet	1) Left	2) Right	3) Both
F) Cramps	1) Left	2) Right	3) Both