



C H I R O P R A C T I C
CONFIDENTIAL PATIENT CASE HISTORY

(Please print clearly and fill in completely)

PATIENT INFORMATION:

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell phone # _____ e-mail: _____

Occupation _____ Work Phone # _____

Employer (Name & Address) _____

Age _____ Birthdate _____ # of Children _____ Marital Status: (circle) M S W D

Spouse's Name _____ Spouse Phone _____

Referred by _____ Nearest Relative & Phone _____

HEALTH INFORMATION:

What is your major complaint? _____

Other complaints _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other _____

How long has it been since you really felt good? _____

List doctors who have treated this condition: _____

List any current medications: Birth control pills other: _____

List past surgeries and dates: _____

List any auto/work related injuries/accidents & dates: _____

FAMILY HEALTH INFORMATION:

Please list spouse, children, parents & siblings:

| Name | Relation | Age | Past and Present Health Status |
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