CHIROPRACTIC

SPORTS THERAPY

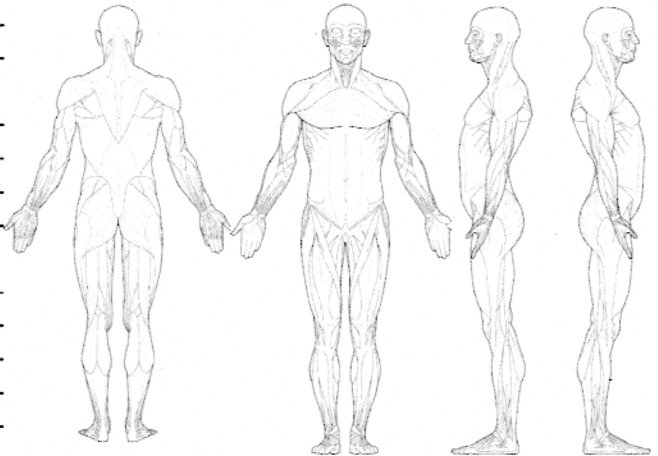
CENTER

CONFIDENTIAL CASE HISTORY

PATIENT NAME ______________________ **TODAY'S DATE** ______________________

1. What is your chief complaint? If more than one, list the worst first):

2. Mark the diagrams below the area(s) of complaint:



3. Which of these apply?
   - Auto Accident/Date:
   - On the job injury/date:
   - Other, describe/include date:

4. Have you received any treatment for this condition? YES / NO
If so, list what, when and by whom & your opinion of the results:

5. How did this condition develop?

6. Have you ever had anything similar to this before? YES / NO If yes, when?

7. Does it radiate to any other part of your body? YES / NO If yes, where?

8. Can you qualify what you feel? DULL ACHING SHARP STABBING STIFF BURNING THROBBING SHOOTING NUMBNESS TINGLING OTHER

9. Is it constant or does it come and go?

10. Has it been getting? BETTER / WORSE / ABOUT THE SAME Over what period of time?

11. What makes it feel better?

12. What makes it feel worse?

PAST MEDICAL HISTORY

1. Have you had any recent illness? YES / NO If yes, describe, include date:

2. List your surgeries / diseases with dates:

3. Most recent set of x-rays: DATE ______ DR. / FACILITY ______
WHERE TAKEN ______ VIEWS TAKEN ______

4. Have you ever had any major falls/blows to the body? YES / NO If yes, describe / include date

5. Have you ever broken any bones? YES / NO If yes describe / include date

6. Have you ever had any strains or sprains? YES / NO If yes describe / include date

7. Have you ever been in an automobile accident? YES / NO If yes describe / include date

DOCTOR'S NOTES