PAAPE CHIROPRACTIC CLINIC **CONFIDENTIAL PATIENT CASE HISTORY**

Name: ________________________________ **Date of Birth:** ___/____/_____ **Age:** ___________

Address: _____________________________ **City:** _____________________ **State:** _____ **Zip:** _________

Home Phone: _____________________**Social Security #:** _________________ ____**Male** ____**Female**

Work Phone: _____________________ **Employer:** ___________________**Occupation:**_______________

Cell Phone: _________________________ **E-mail Address:** _________________________________

Have you been to a chiropractor before? No Yes Who:______________________________________

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___ Separated ___ Other ___

Name of spouse or nearest relative: ____________________________________

Referred to this office by: Friend/Family __ Yellow pages __ Sign __ Other__________________

Which one of our patients referred you to our clinic? ____

Payment for services by: Health Ins __ Cash/Check __ Credit Card __ Workers Comp __ Auto INS ___

How did this problem begin? Job related injury ___ Auto accident ___ Other accident ___ Illness ___
Unknown cause ___ Gradual Onset ___ Other___________________

When did this condition start? ____

If due to an accident on WHAT DATE did accident occur? ____________________________________

Please describe HOW and WHERE condition or accident started: _______________________________

Symptoms are worse in: Morning Afternoon Evening Consistent Unchanged

How long have you had your condition? Hours ____ Days ____ Weeks ____Months ___ Years ___

Symptoms now are: Constant ___ Nearly Constant ___ Come and Go ___

Have you ever had this or similar conditions in the past? NO ___ YES___ _______________________

OTHER Doctors previously seen for this condition: ____

Please CIRCLE the following activities that AGGRAVATE your condition:

Bending	**Coughing**	**Lifting**	**Lying down**	**Reaching**	**Sitting**	**Sneezing**
Standing	**Straining at stool**	**Turning head**	**Walking**	**NONE**	**Other:** ___________________	
Driving	**Standing straight**	**Getting up and down**		**Twisting injured area**		

Please **CIRCLE** the following activities that **RELIEVE** your condition:

Lying down | Reaching | Sitting | Standing | Turning head | Walking | NONE

Heat | Ice | Rest | Stretching | Medication | Bending | Lifting

Other_______________

Please **CIRCLE** any **ADDITIONAL SYMPTOMS** you may be experiencing:

Blurred vision	Depression	Insomnia	Stiff neck	Pins and needles in arms
Buzzing in ears	Diarrhea	Headaches	Stomach upset	Pins and needles in legs
Constipation	Face Flushed	Loss of taste	Loss of balance	Low resistance to colds
Cold feet	Fainting	Loss of smell	Light bothers eyes	Head seems too heavy
Cold hands	Fatigue	Muscle jerking	Numbness in fingers	Dizziness
Cold sweats	Fever	Ringing in ears	Numbness in toes	Shortness of breath
Concentration loss/Confusion		Sensitivity to cold damp weather		NONE ___________

MEDICAL – FAMILY HISTORY- Please indicate which conditions have been experienced by:

S M F	S M F	S M F	S M F
__ Aids/HIV	__ Depression	__ Menstrual cramps	__ Appendicitis
__ Alcohol/Drug	__ Diarrhea	__ M.S.	__ Goiter
__ Allergies	__ Dislocated joints	__Neck pain	__ Mental disorder
__ Anemia	__ Emphysema	__Nervousness	__ Mumps
__ Arthritis	__ Epilepsy	__Numbness	__ Pleurisy
__ Asthma	__ Fainting	__Osteoporosis	__ Pneumonia
__Back pain	__ Fatigue	__ Poor circulation	__ Venereal Infections
__ Bladder trouble	__ Fibromyalgia	__ Polio	__ Whiplash
__ Bowel control	__ Glaucoma	__ Rheumatic fever	__ Whooping cough
__ Bone fracture	__ Headaches	__Reproductive problem	__ Implants
__ Cancer	__ Heart disease	__Sinus	__ Joint replacements
__ Chest pain	__ Heart surgery	__Seizures	__ Pacemaker
__ Concussion	__High blood pressure	__ Scoliosis	__ Lapse of memory
__ Constipation	__High cholesterol	__ Serious injuries	__ Spinal tap
__ Convulsions	__Hepatitis	__ Stroke	__ Spinal injection
__ Diabetes	__HIV	__Thyroid	__ Liver problems
__ Digestive disorder	__ Kidney problems	__ T.B.	__ Bruise easily
__ Dizziness	__Low back pain	__ Ulcers	
__ Deceased	__Lung disease		

SOCIAL HISTORY: (Circle)

Tobacco usage:	None	Light	Moderate	Heavy
Alcohol usage:	None	Light	Moderate	Heavy
Drug usage:	None	Light	Moderate	Heavy

DO YOU EXERCISE:

__ Never
__ Occasional
__ Frequent
__ Seldom

WOMEN:

Are you pregnant? No Yes
Cramps - -- No Yes
Hot Flashes No Yes

Recent weight loss? YES NO ____ lbs

Skin rashes, hives, or lesions? YES NO

Recent weight gain? YES NO ____ lbs

Chest pain or palpitations? YES NO

Shortness of breath, wheezing, or coughing? YES NO

Nausea, vomiting YES NO

Frequency or urgency in urination? -------------- YES NO

Hay fever YES NO

Swelling of lymph nodes YES NO

Postnasal discharge? YES NO

Primary Care Physician? ____

Medication taking now: **Known allergies?** **Vitamin taking now?**

1. ____________________ ____________________ ____________________
2. ____________________ ____________________ ____________________
3. ____________________ ____________________ ____________________
4. ____________________

Height ___'___" **Weight ______lbs** **Date of LAST Physical Exam: __________________**

Have you been treated by a MD for any health condition in the last year? ___NO ___ YES

If YES name of physician: ____

Describe condition: ____

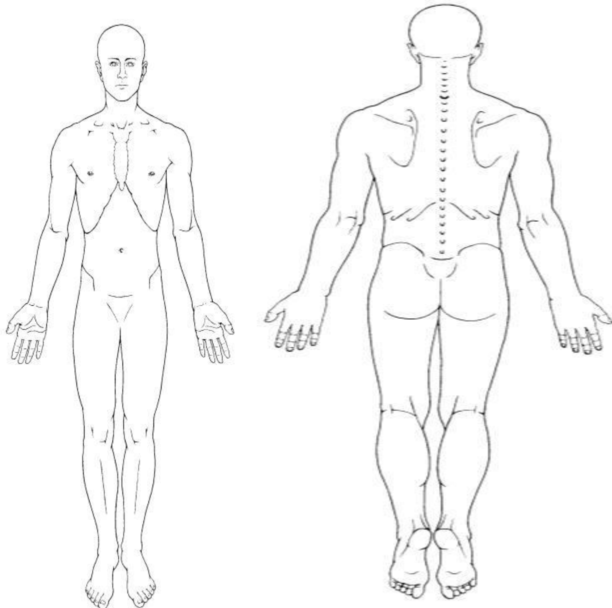
Surgeries you have had? **Broken bones?** **Serious injuries?**

1____________________ **1**____________________ **1**____________________
2____________________ **2**____________________ **2**____________________
3____________________ **3**____________________ **3**____________________
4. **4.** **4.**

What health problem brought you here today?

1. ____
2. ____
3. ____
4. ____

Color in areas of pain on body diagram below:



Front View **Back View**

Right **Left** **Left** **Right**

Place an X next to the left of symptom you have NOW:

	Headaches		***Numbness in legs Rt. Lt.***
	Neck Pain		***Numbness in Arms Rt. Lt.***
	Mid Back Pain		***Numbness in Hands Rt. Lt.***
	Low-back Pain		***Difficulty Sleeping***
	Dizziness		***Pins & Needles in Arms Rt. Lt.***
	Chest/Sternum Pn.		***Pins & Needles in Legs Rt. Lt.***
	Nausea		***Leg Pain Rt. Lt.***
	Nervousness		***Shoulder Pain Rt. Lt.***
	Fatigue		***Foot/Ankle Pain Rt. Lt.***
	Loss of Balance		***General Tension***
	Jaw Pain		***Depression***
	Buzzing in Ears		***Stomach Upset***
	Loss of Memory		***Shortness of Breath***
Write in any other:			

No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

(Please rate intensity of pain on body drawing above)

Place an X to the left of any that apply to you.

Exercise		Work Activity		Sleeping Position		Nutrition	
	None		Sitting longer than 20 minutes		Back		Vitamins
	Moderate		Standing for longer than 1 hour		Sides		Herbs
	Heavy		Light Labor		Stomach		Minerals
	Light		Heavy Labor		All Three		None
					Good Bed?		

Tobacco use? Yes ____ No ____ Former smoker ____

What describes SYMPTOMS? Sharp _ __ Dull ___ Numb ___ Shooting ___ Burning ___ Tingling ____

Symptoms changing? Getting better ____ Not changing ____ Getting worse ____

Who have you seen? No one ____ Chiropractor ____ Medical doctor ____ Physical therapist ____ other? ________________

Similar problem in past? No ______ Yes _____

Signature_______________________________________ Date ____/____/________

Any additional information or questions: