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Case No. \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_
ADDRESS \_\_\_\_\_ SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DL# \_\_\_\_\_
OCCUPATION \_\_\_\_\_ SPOUSE \_\_\_\_\_
EMPLOYER \_\_\_\_\_ SPOUSE'S OCCUPATION \_\_\_\_\_
# OF CHILDREN \_\_\_\_\_ PHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_ EMAIL \_\_\_\_\_
Contact in case of emergency \_\_\_\_\_ REFERRED BY \_\_\_\_\_

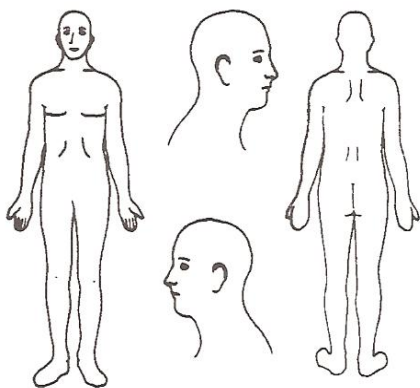
What is your major complaint? \_\_\_\_\_

Other complaints? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or a similar condition in the past? \_\_\_\_\_

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

Please mark your areas of pain on the figures below.



- Neck Problems, Shoulder Problems, Arm Problems, Numbness - Arms, Pain Between Shoulders, Low Back Problems, Leg Problems, Numbness - Legs, Loss of Feeling, Stiff Joints, Painful Joints, Restricts Daily Activities, Restricts Regular Exercise, Sore Muscles, Walking Problems, Broken Bones, Muscle Cramps, Weak Muscles, Headaches, Dizziness, Fainting, Forgetfulness, Depression, Vision Problems, Ear Pain / Noises, Ear Infections, Hearing Loss, Frequent Colds, Allergies, Hay Fever, Asthma, Exzema, Shingles, Nausea, Poor Digestion, Ulcers, Diarrhea, Constipation, Kidney Infection, Menstrual Cramps, Diabetes, Blood Pressure High / Low, Tiredness / Fatigue

- This is a new / old illness. It was not / was treated before. If treated before, what was done?
Name of Doctors:
Have you ever had surgery or been hospitalized?
List Surgeries:
Have you ever had Chiropractic care before?
Name of Doctor:
Date:
Last time you had spinal X-rays or other X-rays:
Medications you now take:

Female: Are you pregnant at this time? Yes [ ] No [ ] Due Date \_\_\_\_\_

From birth to present please list by date / describe

1) Car Accidents \_\_\_\_\_

2) Falls / Injuries (Including Sports) \_\_\_\_\_

3) Other \_\_\_\_\_

Sign & Date: \_\_\_\_\_