

PEEKS CHIROPRACTIC PATIENT CASE HISTORY



Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
Email Address: _____ Contact Preference: Home Work Cell Email
Employer/Occupation: _____ Marital Status: Single Married Divorced Widowed
Date of Birth: _____ Social Security #: _____ - _____ - _____ Gender: Male Female
Race/Ethnicity: Asian African American White Hispanic/Latino Other: _____
Referred by: _____ Previous Chiropractor: _____
Emergency Contact: _____ Phone #: _____ - _____ - _____
Do you smoke? Every day smoker Some day smoker Former smoker Never smoked
Height: _____ Weight: _____

List ALL Past Medical History conditions:

- Arm Pain Arthritis Asthma Broken Bones Cancer Chest Pain Depression Diabetes Dizziness
 Elbow Pain Epilepsy Fainting Fatigue Foot Pain Headaches High Blood Pressure Hip Pain
 Jaw Pain Joint Stiffness Knee Pain Leg Pain Low Back Pain Menstrual Problems Mid-Back Pain
 Neck Pain Neurological Problems Shoulder Pain Spinal Cord Injury Sprain/Strain Stroke/Heart Attack
 Other: _____

List any Surgeries and note year:

- Back _____ Brain _____ Elbow _____ Foot _____ Hip _____ Knee _____
 Neck _____ Neurological _____ Shoulder _____ Wrist _____ Other: _____

Do you nap/sleep on the couch? No Yes

Do you read in bed? No Yes

Do you currently take any medications? No Yes

List any medications you are allergic to: _____

Have you had any auto or other incidents? No Yes

Describe and note year: _____

Have you had in the past year: Blood Test Urinalysis MRI CT Scan Ultrasound X-rays

Please note the reason for the tests _____

For Women Only

Month of last period _____ Are you pregnant? No Yes

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? No Yes

How is your condition changing? Getting better Getting worse Not changing

Please rate your pain (1= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10

Describe the nature of your symptoms: Burning Dull Numb Radiating Pain Sharp Shooting Soreness
 Spasm Stabbing Stiffness Throbbing Tightness Tingling Other: _____

How often do you experience your symptoms? Constantly (76-100% of the day) Frequently (51-75% of the day)
 Occasionally (26-50% of the day) Intermittently (0-25% of the day)

How do your symptoms affect your ability to perform daily activities such as working or driving? (1= no effect and 10= prevents any activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

Dr. Notes: _____

Do you have a SECOND complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? No Yes

How is your condition changing? Getting better Getting worse Not changing

Please rate your pain (1= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10

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What activities aggravate your condition (working, exercise, etc)? _____

Dr. Notes: _____

If you have any other complaints, use additional sheets.

The information given above is accurate and true.

Patient's signature _____ Date _____