Dekalb Chiropractic Center, Inc.

Case History

Date ____/____/____
Patient's Name_____ Preferred Name _____
Social Security No. _____-_____-_____ Date of Birth _____/_____/_____ Age _____
□ Married □ Single □ Divorced □ Separated No. of Children_____ Sex _____
Address_____City_____
State _____ Zip _____ Home Telephone _____-_____ Work Telephone _____-_____
Email address _____
Occupation _____ Employer _____
Work Address _____
City _____ State _____ Zip _____
Spouse's Name _____ Spouse's Date of Birth _____
Spouse's Social Security No. _____-_____-_____ Spouse's Employer _____
Spouse's Employer's Address _____
City _____ State _____ Zip _____
Primary Insurance Company _____
Secondary Insurance Company _____
Insured's Date of Birth _____Referred by _____
Medical Doctor _____ City _____ State _____
Previous Chiropractic Care □ Yes □ No Date of Last Adjustment _____
Doctor's Name _____ City _____ State _____

Rate your health and wellness

Place an '**X**' that denotes where you believe is your current level of wellness.
Place an '**O**' indicating where you would like your wellness to be.

YOUR HEALTH PROFILE

What brings you into our office today? Briefly descibe , including the impact it has had on your life.
_____
_____
Where exactly is the problem? _____
When did the problem occur? _____
How did you injure yourself? _____
Describe the pain of each complaint– (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)
Does this interfere with your; ____Leisure_____Sleep_____Work_____Family_____Sports_____Other
_____
What makes the pain better? _____
What makes the pain worse? _____
Have you tried any home remedies? _____
Have you seen any other doctors for this condition? _____Chiropractor or _____MD _____Other
Name/Address: _____Date_____
What was the diagnosis? _____

GENERAL HISTORY

Have you ever experienced this problem before? When? Was treatment provided? _____
_____
_____

Have you had any slip, falls or auto accidents? _____Yes _____No
If Yes, briefly explain:_____

Have you had any surgeries and/or hospitalizations? _____Yes _____No
If Yes, briefly explain:_____

Please list all medications & supplements you are taking, and why; (prescription and non-prescription)
_____

FEMALE: ARE YOU PREGNANT? _____ If yes, in what month? _____

Social History

Smoker: Yes/No Packs/day_____
Drink _____ cups of coffee per day
Drink _____ alcoholic drinks per day
Stress Level: Low Med High Causes_____

Commute _____ minutes to work
Work _____ hours per week (average)
Exercise _____ hours per week

YOUR GOALS

On a scale of 1 to 10 (1=none, 10=extreme), describe your emotional/psychological/lifestyle stress levels:
Scale=_____Occupational stress: _____
Scale=_____Personal stress: _____

On a scale of 1 to 10 (1=poor, 10 = excellent), describe your habits and condition as it relates to:

Eating_____ Exercise_____ Sleep_____ General Health_____ Wellness lifestyle_____

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals

WELLNESS GOALS

Be Fit. *(Physical)*	Eat Right. *(Nutritional)*	Think Well. *(Psychological)*
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____Please check all that are relevant.

Do You:

__Water-Drink__% your body weight in ounces
__Exercise Regularly
__Take Vitamins

Would you like to know more about:

__Proper Nutrition and meal Planning
__Proper exercise routines and techniques
__How to deal with Lifestyle stress

_____

PAST HISTORY: Please check all that you have or have had

GENERAL SYMPTOMS:
- □ Headaches
- □ Fatigue
- □ Chills
- □ Fever
- □ Sinus Pressure
- □ Weight loss
- □ Allergies
- □ Dizziness
- □ Fainting

SKIN:
- □ Eczema
- □ Skin Eruptions
- □ Boils
- □ Hives
- □ Pimples
- □ Rashes
- □ Dryness

GENITO-URINARY:
- □ Frequent Urination
- □ Painful Urination
- □ Blood in Urine
- □ Bed Wetting
- □ Prostate
- □ Kidney Stone or Infection

GASTRO-INTESTINAL:
- □ Gas/Burning Sensation
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Poor Appetite
- □ Pain in Abdomen
- □ Hemorrhoids
- □ Jaundice

RESPIRATORY:
- □ Chronic Cough
- □ Spitting Blood/Phlegm
- □ Difficult Breathing
- □ Shortness of Breath

CARDIO-VASCULAR
- □ Rapid Heart
- □ Chest Pain
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Heart Attack
- □ Poor Circulation
- □ Stroke

NERVOUS SYSTEM:
- □ Smell
- □ Taste
- □ Eyes
- □ Ears
- □ Sense of Touch
- □ Muscular Movement
- □ Tremors
- □ Incoordination
- □ Equilibrium

FEMALE HISTORY:
- □ Painful Menstruation
- □ Vaginal Discharge
- □ Irregular Cycle
- □ Excessive Flow
- □ Menopause
- □ Breast

PAST ILLNESSES:
- □ Measles
- □ Mumps
- □ Chickenpox
- □ Whooping Cough
- □ Rheumatic Fever
- □ Pneumonia
- □ Anemia
- □ Appendicitis
- □ Diphtheria

MUSCULO-SKELETAL:
- □ Weakness (Describe)_____
_____
- □ Fracture_____
_____
- □ Sprain/Strain_____
_____
- □ Dislocation_____
_____
- □ Congenital Defect_____
_____
- □ Foot Problems_____
_____

CURRENT ILLNESSES/CONDITIONS:
- □ AIDS
- □ Anemia
- □ Arthritis
- □ Cancer
- □ Diabetes
- □ Eczema
- □ Emphysema
- □ Epilepsy
- □ Goiter
- □ Heart Problems
- □ High Blood Pressure
- □ Hypoglycemia
- □ Kidney Disease
- □ Lumbago
- □ Lupus
- □ Migraine headache
- □ Multiple Sclerosis
- □ Polio
- □ Pregnancy
- □ Prostate Problems
- □ Rheumatoid Arthritis
- □ Scoliosis
- □ Stroke
- □ Thyroid Disease
- □ Tuberculosis

FAMILY HISTORY: Please check all that are appropriate and the individual's relation to you
- □ Anemia_____
- □ Arthritis_____
- □ Cancer_____
- □ Chronic Neck Pain_____
- □ Chronic Back Pain_____
- □ Diabetes_____
- □ Eczema_____
- □ Emphysema_____
- □ Epilepsy_____
- □ Heart Problems_____
- □ High Blood Pressure_____
- □ Hypoglycemia_____
- □ Lumbago_____
- □ Migraine Headache_____
- □ Multiple Sclerosis_____
- □ Prostate Problems_____
- □ Psoriasis_____
- □ Rheumatoid Arthritis_____
- □ Scoliosis_____
- □ Spine Surgery_____

To the best of my knowledge, all statements made in the above history are true.

_____
Patient Signature