

Chiropractic Case History

1. Primary reason(s) for seeking chiropractic care:

Primary reason (Chief Complaint): _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint:

Location of Complaint: _____

Complaint Began when and how? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

How frequent is complaint present, how long does it last? _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Does anything make the complaint better? _____

Does anything aggravate the complaint? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

4. Past Health History:

Previous major illnesses, injury or trauma: _____

Allergies: _____

Medications: _____ Reason for taking: _____

Surgeries/Date: _____ Type of Surgery: _____

Females – Pregnancies/Date of Delivery: _____ Outcome: _____

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family: Cause of death _____ Age at death _____

6. Social and Occupational History:

Level of Education: high school some college college graduate post graduate studies

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

Functional Rating Index

Use for the primary complaint. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0- No Pain 1- Mild Pain 2- Moderate Pain 3- Severe Pain 4- Worst Possible Pain

2. Sleeping

0- Perfect Sleep 1- Mildly Disturbed 2- Moderately Disturbed 3- Greatly Disturbed 4- Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0- No Pain
No Restrictions 1- Mild Pain;
No Restrictions 2- Moderate Pain;
Go Slowly 3- Moderate Pain;
Some Assistance 4- Severe Pain;
100% Assistance

4. Travel (driving, etc.)

0- No Pain on
Long Trips 1- Mild Pain on
Long Trips 2- Moderate Pain on
Long Trips 3- Moderate Pain on
Short Trips 4- Severe Pain on
Short Trips

5. Work

0- Usual Work + Extra 1- Usual Work, No Extra 2- 50% of Usual Work 3- 25% of Usual Work 4- Cannot Work

6. Recreation

0- All Activities 1- Most Activities 2- Some Activities 3- Few Activities 4- No Activities

7. Frequency of Pain

0- No Pain 1- Occasional (25%) 2- Intermittent (50%) 3- Frequent (75%) 4- Constant (100%)

8. Lifting

0- No Pain with
Heavy Weight 1- Increased Pain with
Heavy Weight 2- Increased Pain with
Moderate Weight 3- Increased Pain with
Light Weight 4- Increased Pain with
Any Weight

9. Walking

0- No Pain with
Any Distance 1- Increased Pain after
1 Mile 2- Increased Pain after
½ Mile 3- Increased Pain after
¼ Mile 4- Increased Pain after
Any Distance

10. Standing

0- No Pain with
Any Time 1- Increased Pain after
Several Hours 2- Increased Pain after
1 Hour 3- Increased Pain after
½ Hour 4- Increased Pain after
Any Time

Total _____ (/4, X10) = Functional Rating Score _____ %

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____