O'BRIEN CHIROPRACTIC

CONFIDENTIAL CASE HISTORY RECORD

Please fill out the following form in as much detail as possible.

Please Print Date_____ MRN No._____

Name _____ Nick Name _____ Date of Birth _____

Address_____
Street City County State Zip

Home Phone _____ Work # _____ Cell # _____

Email_____ Occupation/Job_____ ❍ Full Time ❍ Part Time ❍ Self

Employer _____
Name Address Phone

SS#_____/_____/_____ Sex ❍ M ❍ F Referred by _____

Marital Status: ❍ M ❍ S ❍ D ❍ W Children (#)_____ Name of Spouse _____

We must ask the following information regarding ethnicity, race and religion per government requirements. If you would like to decline please indicate that in the space provided. Thank you.

Race:_____ Ethnicity: ❍ Hispanic/Latino ❍ Non Hispanic ❍ Refused Religion _____

Is any other member of your family being treated at this office? _____

Have you ever had chiropractic care before? _____ Where? _____

For what problem? _____Last treated _____

Were the results satisfactory? ❍ Yes ❍ No

Major complaints and symptoms in order of severity or concerns

_____

_____

_____

_____

_____

How do you believe your problem (pain) began?

_____

_____

_____

_____

When did you first notice this current problem/pain? _____

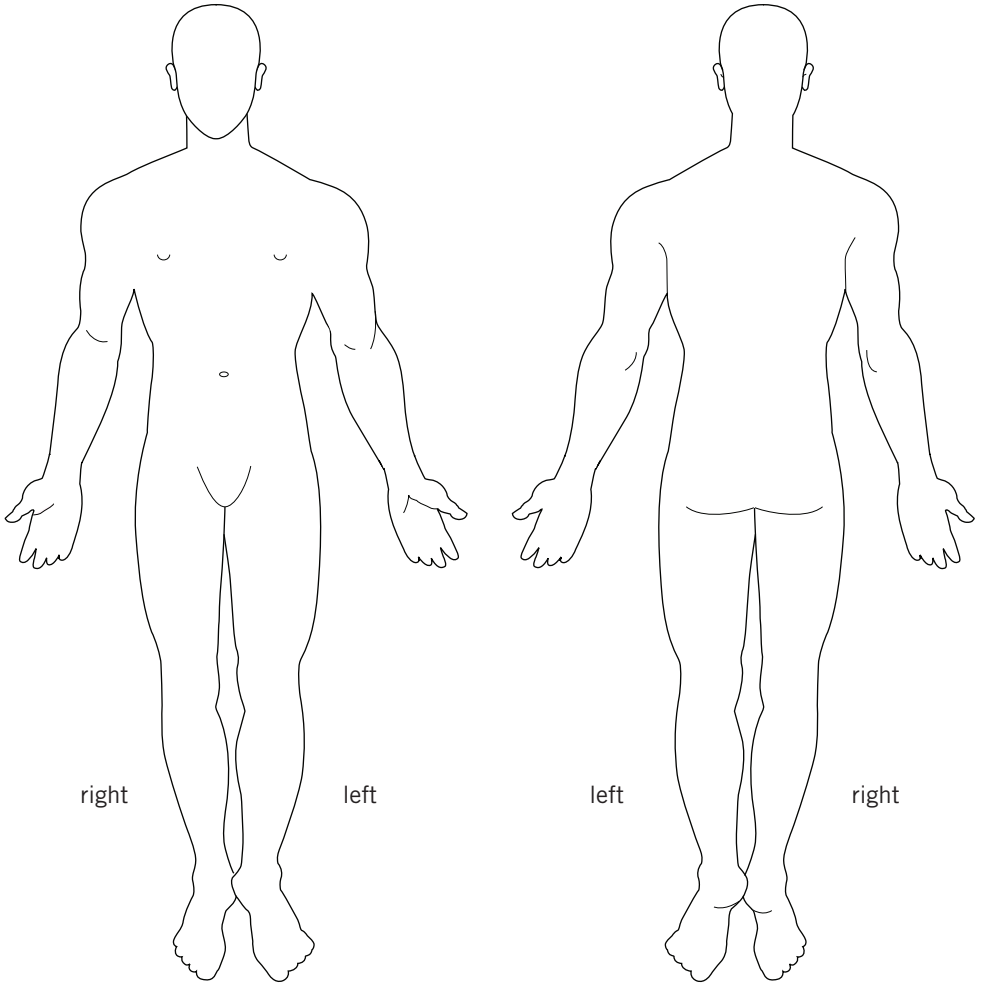
Have you lost any work? ❍ Yes ❍ No Day and date you last worked _____

PAIN CHART

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark the areas where the pain radiates – include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	XXXXX	ZZZZZ	/ / / / /
- - - - -	00000	XXXXX	ZZZZZ	/ / / / /
- - - - -	00000	XXXXX	ZZZZZ	/ / / / /
- - - - -	00000	XXXXX	ZZZZZ	/ / / / /



RATE YOUR PAIN: 0 = NO PAIN 10 = MOST INTENSE PAIN IMAGINABLE

1. At its worst 0 1 2 3 4 5 6 7 8 9 10
2. Right now 0 1 2 3 4 5 6 7 8 9 10
3. At its best 0 1 2 3 4 5 6 7 8 9 10

Have you ever had this condition before or a similar condition? ❍ Yes ❍ No When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you been treated by a Medical Physician for this ailment? ❍ Yes ❍ No Where? _____

Describe the type of treatment _____

When _____

Length of time under care _____ Results _____

Family History: List any immediate family member who has had any of the following:

Enter (M) – Mother; (F) – Father; (B) – Brother; (S) – Sister

( ) High Blood Pressure	( ) Kidney Disease
( ) Heart Attack	( ) Stroke
( ) Emphysema	( ) Arthritis
( ) Asthma	( ) Mental Illness
( ) Seizures	( ) Cancer
( ) Diabetes	( ) Thyroid Disease
( ) Circulation Problems	( ) Colitis

Family Physician's Name _____ Phone _____

Emergency Contact _____ Phone _____

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)? _____

When?_____

Are you allergic to anything you are aware of? _____

Current medications (including aspirin)? ❍ Yes ❍ No Illicit drugs? ❍ Yes ❍ No Corticosteroid? ❍ Yes ❍ No

If Yes, name them_____

Have you ever broken any bones? (fractures)? _____ Any dislocations?_____

What operations have you had? _____ Year _____

_____ Year _____

_____ Year _____

Give dates you have any of the following (if exact date unknown, give approximate date)

Blood tests _____ MRI or CT Scan_____

X-ray examination _____ Bone Scan _____

At what hospital or office were these tests taken?_____

Do you have a history of drug or alcohol dependence? ❍ Yes ❍ No

Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? ❍ Yes ❍ No

Do you have any health problems not listed above? _____

Have you ever had cancer? ❍ Yes ❍ No Where?_____

Does your pain wake you from sound sleep? ❍ Yes ❍ No

Have you lost ❍ Yes ❍ No or gained ❍ Yes ❍ No weight in the past year? How much?_____

Habits: (Please check)

❍ Cigarettes? Current Quantity _____ Former Quantity _____ Second hand smoke? ❍ Yes ❍ No

❍ Coffee? Quantity _____ ❍ Alcohol? Quantity _____ ❍ Tea? Quantity _____

Activities/Hobbies _____

_____

Please list any vitamins you take _____

_____

Use this space for any additional information you may wish to discuss_____

_____

_____

Review of Systems

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please check the now or past column if it applies to you.

	Now	Past		Now	Past		Now	Past
Headaches	_____	_____	Loss of Memory	_____	_____	Cold Hands	_____	_____
Neck Pain	_____	_____	Chest Pains	_____	_____	Cold Feet	_____	_____
Mid Back Pain	_____	_____	Shortness of Breath	_____	_____	Leg Cramps	_____	_____
Low Back Pain	_____	_____	Asthma	_____	_____	Fever	_____	_____
Arm/Hand Pain	_____	_____	Frequent Colds	_____	_____	Night Sweats	_____	_____
Arm/Hand Numbness	_____	_____	Sinus Problems	_____	_____	Stomach Upset	_____	_____
Arm/Hand Weakness	_____	_____	Arthritis	_____	_____	Indigestion	_____	_____
Leg/Foot Pain	_____	_____	Swollen Joints	_____	_____	Belching	_____	_____
Leg/Foot Numbness	_____	_____	Muscle Spasms	_____	_____	Vomiting	_____	_____
Leg/Foot Weakness	_____	_____	Nervousness	_____	_____	Diarrhea	_____	_____
Fainting	_____	_____	Tension	_____	_____	Constipation	_____	_____
Dizziness	_____	_____	Irritability	_____	_____	Colitis	_____	_____
Loss of Balance	_____	_____	Fatigue	_____	_____	Hemorrhoids	_____	_____
Ringing in Ears	_____	_____	Depression	_____	_____	Urinary Problems	_____	_____
Blurred Vision	_____	_____	Sleeping Problems	_____	_____	Bowel Problems	_____	_____
Loss of Smell	_____	_____	Menstrual Difficulties	_____	_____	Diabetes	_____	_____
Loss of Taste	_____	_____	High Blood Pressure	_____	_____	Osteoporosis/Osteopenia	_____	_____

I understand that a complete and accurate case history is necessary for the Doctor to provide the most appropriate treatment. I hereby acknowledge that the above information is accurate and complete to the best of my knowledge and recollection, and that I haven't knowingly omitted any information in regard to my medical history.

PATIENT'S SIGNATURE_____ DATE_____

PLEASE PRINT NAME _____