Date____/_____/_____ VRC#_______________
Staff use only

LIFE IS GOOD CHIROPRACTIC
CONFIDENTIAL PATIENT CASE HISTORY

Name ____Age ______ Birth Date _________________ Sex:_____Male ____Female

Address ____City ___________________________State ________ Zip _________

Home Telephone (____)________-_________Cell Number (_____)________-__________Email Address: _________________________________

Occupation __________________________ Marital Status: M S W D # Children __________ Spouse's Name _____________________

How did you hear about our office? ____

Health Information

Have you had previous chiropractic care? _________ If yes, when? __________

I am here for wellness care only ________

1. What is your major complaint? ____

Other Complaints: ____

2. Where is the symptom? ____

3. When did the *symptom* ***first*** start? ____

Have you had this or similar conditions in the past? ____

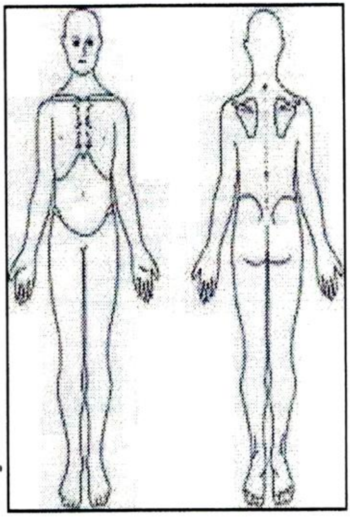
4. How would you describe your pain? (**Check** more than one if necessary to describe your problem)
____Stiffness ____Weakness ____ Sharp ____Dull ____Burning ____ Numbness & tingling
____Pressure ____Throbbing ____ Tearing ____Achy ____ Soreness ____Travels
____Constant ____Comes & goes ____ Makes a grinding noise ____ Knot

5. How often are your symptoms present? 0-25% 26-50% 81-75% 76-100%
(Intermittent) *(Constant)*

6. What activities aggravate your condition? (**Check** more than one if necessary to describe your problem)
____Working ____ Lifting ____ Standing ____Coughing ____ Lying down
____Sex ____ Walking ____Chores ____Stress ____Running
____ Exercising ____ Flexion ____Extension ____ Sleeping ____ Driving
Turning ____ Left or ____Right ____Walking up stairs ____Sitting after standing
Bending ____Left or ____Right ____Walking down stairs ____Standing after sitting

7. It interferes with: ____Work ____Sleep ____Walking ____Sitting ____Hobbies ____Leisure

8. What alleviates your condition? (**Check** more than one if necessary to describe your problem)
____Resting ____ Sitting ____Standing ____Using ice
____Using heat ____Stretching ____Moving around ____ Adjustments
____Laying down ____Sleeping ____Exercise ____Massage
____Prescription medication ____OTC medication ____Taking time off work



Please outline on the diagram the area of your discomfort.

Female Use Only:
Is there any chance that you may be pregnant
If Yes, due date
____/____/____ No___

9. How long has it been since you really felt good? ____

10. Other doctors who treated this condition ____

11. List surgical operations and years: ____

12. Medications you now take: ___Pain killer's ___ Nerve pills ___ Muscle relaxes ___Insulin ___Hormone ___Tranquilizer

___ Anti Inflammatory ___Allergy meds ___Mood related drugs ___ Blood Pressure ____No Meds Other meds _____________________________

13. Have you been in an auto accident? _____ Past Year _____ Past 5 years _____ Over 5 years _____ Never
Describe: ____

14. Have you had any personal injury or accident? ____ Past Year ____ Past 5 years _____ Over 5 years _____ None
Describe: ____

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Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood Years	Yes	No	Unsure
Did you have any childhood illness?	___	___	___
Was there a prolonged use of medicine?	___	___	___
Did you have any falls from height over 3 feet (i.e. crib, bunks)?	___	___	___
Did you play youth sports?	___	___	___

Adult Years (18-present)	Yes	No	Comments
Do/did you smoke?	___	___	_________
Do/ did you drink alcohol?	___	___	_________
Have you been in any accidents?	___	___	_________
Do/did you play adult/extreme sports?	___	___	_________
Do/did you take any drugs?	___	___	_________

Have you suffered from? Please mark P for Past, C for Currently, N for Never and or O for Occasionally

____Arthritis
____Fatigue
____Asthma
____Sinus trouble
____Sleep disorders
____Digestive disorder s
____Allergies
____Heart trouble
____Diabetes
____Numbness in fingers/hands
____Headaches
____Neck pain
____Pain between shoulders
____Shoulder pain
____Arm pain
____Elbow pain
____Hand/finger/wrist pain
____Carpal tunnel
____Low back pain
____Mid back pain
____Backaches
____Hip pain / Thigh pain
____Knee pain
____Pain down back of leg
____Numbness in toes/feet
____Concentration problems
____Menstrual pain/irregular
____Pins & needles
____Cold feet /Cold hands
____Dizziness
____Loss of balance
____Ringing/Buzzing ears
____Mood swings /Depression
____Tension
____Nervousness
Other _______________

Family History

1. Does anyone in your family suffer with the same condition(s) ____Yes ____No

   If yes whom ____Grandmother ____ Grandfather ____ Mother ____ Father ____ Sister(s) ____ Brother(s) ____ Son(s) ____ Daughter(s)

   Have they ever been treated for their condition? ____No ____ Yes ____ I don't know

2. Any other hereditary conditions the doctor should be aware of? ____ Yes ____No. If yes _____________________________________

At our office we are not only interested in your well being, but also the health and well being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children ____

Spouse ____

Mother/ father ____

Siblings ____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? ____Yes ___No Do you have health insurance? ___Yes ____No

Name of insurance company_________________________________ Policy # ____

Policy holder's name _________________________________ D.O.B ____/______/_____ Phone # (   ) _______-__________

Do you have a secondary/ supplement? If so, policy name _________________________ Policy #___________________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and my self. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me with collecting from the insurance company and that any amount authorized to be paid directly to this Chiropractic office, will be credited my account on receipt. However, I clearly understand and agree that all services rendered me are charged to me directly and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Print Name:_______________________________________ Patient's Signature:____

Parent or Guardian Signature: ______________________________________ Date: _______/_______/_______

Doctor's Signature: ____