Date____/_____/_____ VRC#_____

Staff use only

LIFE IS GOOD CHIROPRACTIC
CONFIDENTIAL 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 primary complaint: _____

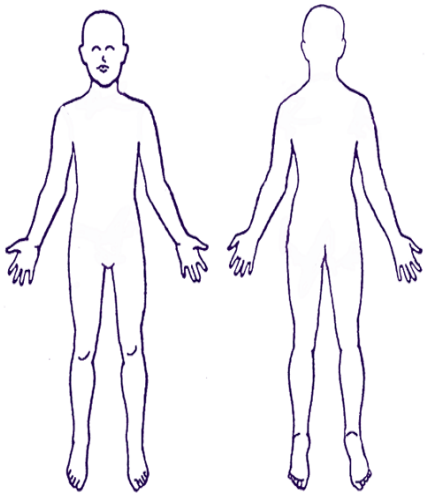
Other Complaints: _____

2. When did the primary symptom **first** start? _____

3. **How** did the primary Symptom **first** Start? _____

4. Have you had this or similar conditions in the past?_____

Please mark on the diagram the area of your discomfort



5. How would you describe your primary complaint?
(Check more than one if necessary to describe your problem)
____Stiffness ____Weakness ____ Sharp ____Dull ____Burning
____ Numbness & Tingling ____Pressure ____Throbbing ____ Tearing ____Achy
____ Soreness ____Travels ____Knot ____ Makes a grinding noise

6. How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%
(Intermittent) *(Constant)*

7. What activities aggravate your condition? (Check more than one if necessary to describe your problem)
____Working ____ Lifting ____ Standing ____Coughing ____ Lying down
____Driving ____ Walking ____Chores ____Stress ____Running
____ Exercising ____ Flexion ____Extension ____ Sleeping ____ Getting dressed
____Yard work ____ Doing dishes ____Sweeping/Vacuuming ___ Sitting long periods of time
Turning ____ Left or ____Right ____Walking up stairs ____Sitting after standing
Bending ____Left or ____Right ____Walking down stairs ____Standing after sitting

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

9. 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

10. How long has it been since you really felt good? _____

11. Other doctors who treated this condition _____

12. List surgical operations and years: _____

13. 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 _____

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14. Have you been in an auto accident? _____ Past Year _____ Past 5 years _____ Over 5 years _____ Never

Describe: _____

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

Describe: _____

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.

	Yes	No	Unsure		Yes	No
Did you have any severe childhood illness?	___	___	___	Do/ did you drink alcohol?	___	___
Was there a prolonged use of medication?	___	___	___	Do/ did you smoke?	___	___

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

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

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)

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 _____

Female Only: Is there any chance that you may be pregnant if yes, due date ____/____/____ No_____

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 myself. 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: _____ Date: _____/_____/_____