Lake Texoma CHIROPRACTIC

Name: _____

Today's Date: _____

Date of Birth: _____

Phone Number: _____

Address: _____

Email: _____

Confidential Patient Case History

What is your major complaint/problem/reason for visit?_____
_____
_____

How long have you had your major complaint? _____Years _____Months _____Weeks _____Days

Have you has this or similar conditions in the past? YES NO When?_____

Can you relate this problem to a: Sports Injury_____ Hobby_____ Work Accident_____ Car Accident_____ Fall_____ Other _____

Pain is: **Constant** **Comes/Goes**

Is your condition: Getting Worse_____ Getting Better_____ Unchanged_____

What activities **aggravate** your condition(s)? Sitting / Standing / Walking / Bending / Lying Down / Driving

What activities **relieve/ease** your condition(s)? Sitting / Standing / Walking / Bending / Lying Down / Driving

Are your condition(s) worse during certain times of the day? _____

Have you had any tests for your problem? □ X-ray □ MRI or CAT scan □ EMG □ Bone Scan □ Blood Work

Have you ever had previous chiropractic care? YES NO If yes, date of last care_____

List the doctors/therapists/specialists seen for this problem and treatment given:
1._____
2._____
3._____

When was the last time you felt as well as you would like to feel?_____

Would you say your OVERALL HEALTH has been:
□ Steadily improving □Gradually declining □Unpredictably up and down □ Unchanging

MEDICAL HISTORY

Check any of the following symptoms you have noticed: (□= Previously, ☼= Now)

P/N		P/N		P/N	
□ ☼	Headaches	□ ☼	Low back pain	□ ☼	Sensitive to light or sound
□ ☼	Dizziness or light-headed	□ ☼	Leg/foot numbness/tingling	□ ☼	Visual or hearing disturbance
□ ☼	Jaw pain, clicking, or locking	□ ☼	Leg/foot fatigue/weakness	□ ☼	Memory loss/problems
□ ☼	Pain or difficulty swallowing	□ ☼	Leg pain with walking	□ ☼	Irritability or depression
□ ☼	Neck pain or stiffness	□ ☼	Abdominal pain	□ ☼	Fatigue or loss of energy
□ ☼	Shoulder pain	□ ☼	Nausea or vomiting	□ ☼	Fainting or convulsions
□ ☼	Mid back pain	□ ☼	Diarrhea or constipation	□ ☼	Trouble with balance or coordination
□ ☼	Chest pain or cough	□ ☼	Blood in urine or stool	□ ☼	Sleep disturbances/problems
□ ☼	Pain/trouble breathing	□ ☼	Difficulty or pain w/ urination	□ ☼	Rashes (face, body, limbs)
□ ☼	Arm/hand numbness/tingling	□ ☼	Difficulty with sexual function	□ ☼	Joint pain or swelling
□ ☼	Arm/hand fatigue/weakness	□ ☼	Abnormal menstrual periods	□ ☼	Pain with exertion/activity

Are you taking any prescription medications? Yes No

If yes, list all medication and the reason used:
Medication:_____ Use:_____
Medication:_____ Use:_____
Medication:_____ Use:_____
Medication:_____ Use:_____

Are you taking any vitamins, herbs, over-the-counter medications, home remedies? _____
_____

List any surgeries (include dates and reason):_____

List any hospitalizations:_____

List any auto accidents:_____

List any job injuries:_____

List any head injuries/broken bones:_____

List any current or past medical conditions that you have had (cancer, diabetes, heart disease, arthritis, osteoporosis, high blood pressure, stroke etc.):_____

_____

List any health conditions that run in your family: (cancer, diabetes, heart disease, arthritis, back problems, other):_____

Age of mattress _____year(s) □Comfortable □Uncomfortable

Habits:

Alcohol	_____Drinks/Week
Smoking	_____Packs/Day
Coffee/Caffeine Drinks	_____Cups/Day
Exercise	_____Times/Week
High Stress	_____Reason