



3611 Woodland Park Ave. N. #100  
Seattle, WA 98103  
Ph: (206) 826-1005  
Fax: (206) 826-1289

**CASE HISTORY**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Have you ever received Chiropractic Care? YES NO

**SYMPTOMS**

Primary Complaint \_\_\_\_\_ When did it start? \_\_\_\_\_

Is this problem caused by an accident, injury, or fall? YES NO

Type of Injury: Auto Work Home Other \_\_\_\_\_ Have you reported it? Yes No

Pains are: Sharp Dull Throbbing Aching Numbness Shooting

Burning Tingling Cramps Stiffness Swelling Other \_\_\_\_\_

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Rate the priority level of your desire to *correct* this problem. (1, low-10, high): 1 2 3 4 5 6 7 8 9 10

Is this condition getting progressively worse? Yes No Unknown

Is the pain constant or does it come and go? \_\_\_\_\_ How often do you have it? \_\_\_\_\_

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are difficult to perform:

Sitting Standing Walking Bending Lying Down Other \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

What treatment have you already received for this condition? Medications Physical Therapy Surgery

Chiropractic None Other \_\_\_\_\_

Name of Doctors who treated you for this condition \_\_\_\_\_

**OTHER SYMPTOMS**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Numbness in Fingers/ Toes | <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Pins & Needles in Legs  |
| <input type="checkbox"/> Loss of Smell      | <input type="checkbox"/> Low Back Pain             | <input type="checkbox"/> Ears Ringing/Buzzing | <input type="checkbox"/> Shortness of Breath     |
| <input type="checkbox"/> Chest Pain         | <input type="checkbox"/> Loss of Taste             | <input type="checkbox"/> Hip Pain             | <input type="checkbox"/> Upper Back Pain         |
| <input type="checkbox"/> Stomach Upset      | <input type="checkbox"/> Leg Pain                  | <input type="checkbox"/> Dizziness/ Fainting  | <input type="checkbox"/> Tension                 |
| <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Pins & Needles in Arms    | <input type="checkbox"/> Mid Back Pain        | <input type="checkbox"/> Diarrhea / Constipation |
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Neck Pain                 | <input type="checkbox"/> Depression           | <input type="checkbox"/> Loss of Memory          |
| <input type="checkbox"/> Shoulder Pain      | <input type="checkbox"/> Cold Hands/Cold Feet      | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Irritability            |

(Women) Are you Pregnant? YES NO Nursing? YES NO Taking Birth Control? YES NO

**DAILY HABITS**

Exercise: None Moderate Daily Heavy Types of exercise: \_\_\_\_\_

Work Habits: Sitting Standing Light Labor Heavy Labor Occupation: \_\_\_\_\_

Sleep Position: Side Stomach Back # hours/ night \_\_\_\_\_

Do you follow a healthy diet? Yes No Would you be willing to have a nutrition consultation? Yes No

Do You Smoke? Yes No Packs/ Day \_\_\_\_\_

Do You Drink Alcohol? Yes No Drinks/ Week \_\_\_\_\_

Coffee/ Caffeine Drinks? Yes No Cups/ Day \_\_\_\_\_

Do You Have High Stress? Yes No Reason \_\_\_\_\_

What Vitamins/Nutritional Supplements do you take? \_\_\_\_\_

What Medications are you taking? \_\_\_\_\_

**HEALTH HISTORY**

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Auto Accidents	_____	_____
Other	_____	_____

Mark only those conditions that you have either had in the past or currently have:

- |  |  |   |  |   |   |
|--|--|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV          | <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Anorexia             | <input type="checkbox"/> Appendicitis       |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Bulimia              | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Depression          | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Emphysema          |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Gonorrhea            | <input type="checkbox"/> Gout               |
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Herpes              | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Liver Disease     | <input type="checkbox"/> Measles             | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Mononucleosis        | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Mumps             | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> Polio             | <input type="checkbox"/> Prostate Problems   | <input type="checkbox"/> Prosthesis         | <input type="checkbox"/> Psychiatric Care    | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Scarlet Fever     | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Suicide Attempt    | <input type="checkbox"/> Thyroid Problems    | <input type="checkbox"/> Tonsillitis          | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Tumors, Growths   | <input type="checkbox"/> Typhoid Fever       | <input type="checkbox"/> Ulcers             | <input type="checkbox"/> Vaginal Infections  | <input type="checkbox"/> Venereal Disease     | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Other _____       |  |   |  |   |   |

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes
Mother's Side:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's Side:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When you were a child:

- Did you have a difficult birth process? YES NO  Caesarean  Breach  Forceps
- Did you fall or have other traumas? YES NO
- Were you shaken, yanked or abused? YES NO

Have you been taught proper body movement and care? YES NO

**MY HEALTH ATTITUDE-** Please mark which one applies to you

- Treatment Only-** I only consult a doctor when I have an ache or pain and discontinue as soon as it is cleared up
- Prevention-** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring
- Maintaining Health-** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- Family Health-** I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_