Williams Family Chiropractic
Chiropractic Case History

Name_____ Sex ( )Male ( )Female Date_____
Address_____ City_____ State_____ Zip_____
Phone# Home _____ Work_____ Cell_____ Date Of Birth_____ Age_____
Soc. Sec. #_____ Occupation_____ Employer_____
Marital Status_____ Spouses Name_____
Spouse's Occupation_____ Number of Children_____
Have you ever received chiropractic care? ( )Yes ( )No Physical Therapy? ( )Yes ( )No
If yes, when? _____ For what condition?_____
How did you hear about this facility?_____

Reasons for Seeking Chiropractic Care/Chief Complaint:_____
_____
Location of complaint_____
Complaint began when & how?_____
_____
Please list any and all treatments that you have received for this complaint_____
_____

What prescription or over the counter drugs are you now taking?
Medication_____ How much/long_____ Reason for taking_____
Medication_____ How much/long_____ Reason for taking_____
Medication_____ How much/long_____ Reason for taking_____

What Surgeries have you had?
Date_____ Type of surgery_____
Date_____ Type of surgery_____
Date_____ Type of surgery_____

FEMALES ONLY

Are you currently pregnant ( ) Yes ( ) No If Yes, how many weeks?_____
Regarding previous pregnancies: Natural Birth? ( ) Yes ( ) No
Cesarean/C-section? ( ) Yes ( ) No
Forceps or extraction used? ( ) Yes ( ) No
Drugs administered during the delivery? ( ) Yes ( ) No

HEALTH HISTORY

Did/Do you smoke? ( ) Yes ( ) No If yes, how much?_____
Did/do you drink alcohol? ( ) Yes ( ) No If yes, how much?_____ How often?_____
Do you exercise regularly exercise? ( ) Yes ( ) No If yes, how often?_____ What type?_____
Do you take vitamins or supplements? ( ) Yes ( ) No
How much sleep do you average per night? _____hours

Description of activities related to your job_____
_____
What Sports or recreational activities have you done in the past or present? _____
_____
What sport injuries have you had?_____
Have you ever broken any bones?_____
Previous injury or trauma_____

IN CASE OF EMERGENCY

Please contact_____ Relationship_____
Emergency Phone_____ Primary Care Physician_____

CURRENT MEDICAL COMPLAINTS

Are you ( ) Improved ( ) Unchanged ( ) Getting worse

BACK PAIN (Upper, Mid, Lower) (If none, leave this section 1-10, blank)

1. Currently I have pain in my ( ) low back ( ) mid back ( ) upper back
2. My pain is described as ( ) Dull ache/ stiffness ( ) sharp ( ) other_____
3. Currently my pain is ( ) minimal ( ) slight ( ) moderate ( ) severe
4. I have pain ( ) sometimes ( ) all the time
   If sometimes, it lasts _____minutes/hours at a time and occurs _____days per week
5. My pain low back pain goes into my ( ) right leg ( ) left leg ( ) both ( ) neither
6. I have tingling and/or numbness in my ( ) right leg ( ) left leg ( ) both ( ) neither
7. My low back pain is worse when I:
   (Check all that apply)
   ( ) sit If yes, after how long? _____minutes/ hours
   ( ) stand If yes, after how long? _____minutes/ hours
   ( ) walk If yes, after how long? _____minutes/ hours
   ( ) bend
   ( ) lift If yes, lifting what? _____
   ( ) push/pull
   ( ) other_____
8. My back pain wakes me up at night? ( ) Yes ( ) No
9. Do you have a bowel or bladder dysfunction as a result of this condition? ( ) Yes ( )No
10. What makes the pain(s) feel better _____

NECK PAIN & HEADACHE (If none, leave this section 1-10, blank)

1. My pain is described as ( ) dull ache/ stiffness ( ) sharp ( ) other_____
2. Currently my pain is ( ) minimal ( ) slight ( ) moderate ( ) severe
3. I have pain ( ) sometimes ( ) all the time
   If sometimes, it lasts _____minutes/hours at a time and occurs _____days per week
4. My pain goes into my ( ) right arm ( ) left arm ( ) both
5. I have tingling and/or numbness in my ( ) right arm ( ) left arm ( ) both
6. My neck pain is worse when I:
   (Check all that apply)
   ( ) bend head forward
   ( ) lift
   ( ) pull/ push
   ( ) turn my head
   ( ) other_____
7. My neck pain wakes me up during the night ( ) Yes ( ) No
8. I have headaches ( ) Yes ( ) No If yes, on what part of the head are they?_____
9. If I do get headaches, they occur ( ) all the time ( ) sometimes, _____days/wk
10. What makes the pain(s) feel better _____

FAMILY HISTORY

Please mark the following if found in immediate family or yourself:

	Self	Mother	Father	Sibling
Diabetes	____	____	____	____
High Blood Pressure	____	____	____	____
Heart Disease	____	____	____	____
Kidney Disease	____	____	____	____
Cancer	____	____	____	____
Arthritis	____	____	____	____
Other_____	____	____	____	____
Seizures	____			
Metal Implants	____			
Pacemaker	____			

Describe any current complaints that were not previously covered on this questionnaire, or list any additional comments _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information that I have provided.

_____ _____ _____

Self, Parent or Guardian Signature | Print Name | Date