PATIENT CASE HISTORY

Name: ____

Address: ______________________________ City: ______________

State: __________ Zip: ____________ Home Phone: _____-_____-_______ Work Phone: _____-_____-_______

Cell Phone: _____-_____-_______ Email Address: ____________________ Occupation: ______________

Date of Birth: ____________ Social Security # ______-______-______ Gender: ☐ Male ☐ Female

Referred by: ____

CHECK ANY ALLERGIES:

☐ Animals ☐ Chocolate ☐ Eggs ☐ Penicillin ☐ Seasonal Allergies ☐ Wheat
☐ Aspirin ☐ Dairy ☐ Latex ☐ Ragweed/Pollen ☐ Shellfish ☐ X-Ray Dye
☐ Bees ☐ Dust ☐ Molds ☐ Rubber ☐ Soaps ☐ Other: ______________

CHECK ANY SURGERIES:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee
☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: ____________

CHECK ALL PAST MEDICAL HISTORY CONDITIONS:

☐ Ankle Pain ☐ Dizziness ☐ Headaches ☐ Leg Pain ☐ Polio
☐ Arm Pain ☐ Elbow Pain ☐ Hearing Problems ☐ Menstrual Problems ☐ Prostate Problems
☐ Arthritis ☐ Epilepsy ☐ Hepatitis ☐ Mid-Back Pain ☐ Shoulder Pain'
☐ Back Pain ☐ Eye/Vision Problems ☐ High Blood Pressure ☐ Minor Heart Problem ☐ Significant Weight Change'
☐ Broken Bones ☐ Fainting ☐ Hip Pain ☐ Multiple Sclerosis ☐ Spinal Cord Injury
☐ Cancer ☐ Fatigue ☐ HIV ☐ Neck Pain ☐ Sprain/Strain
☐ Chest Pain ☐ Foot Pain ☐ Jaw Pain ☐ Neurological Problems ☐ Stroke/Heart Attack
☐ Depression ☐ Genetic Spinal Condition ☐ Joint Stiffness ☐ Pacemaker ☐ Other: ____________
☐ Diabetes ☐ Hand Pain ☐ Knee Pain ☐ Parkinson's

CHECK ANY MEDICATIONS YOU ARE TAKING:

☐ Anxiety ☐ Pain Killers ☐ Birth Control ☐ Allergy ☐ Other: ______________
☐ Muscle Relaxers ☐ Insulin ☐ Cardiovascular ☐ Seizure

CHECK YOUR FAMILY HISTORY:

☐ Arthritis ☐ Depression ☐ High Blood Pressure ☐ Parkinson's Polio
☐ Asthma ☐ Diabetes ☐ Heart Problems ☐ Prostate Problems
☐ Back Pain ☐ Epilepsy ☐ Multiple Sclerosis ☐ Stroke/Heart Attach
☐ Cancer ☐ Genetic Spinal Condition ☐ Neurological Problems

PLEASE LIST ALL FAMILY MEMBERS WHO HAD/HAS ANY OF THE ABOVE PROBLEMS:

(Example; Grandmother – High blood pressure)

______________________________ ______________________________
______________________________ ______________________________

HAVE YOU HAD ANY AUTO OR OTHER ACCIDENTS? ☐ NO ☐ YES

Describe: ______________________________

DATE OF LAST PHYSICAL EXAMINATION: ______________

DO YOU DRINK ALCOHOL? ☐ No ☐ Yes - how many per day?________

DO YOU DRINK CAFFEINE? ☐ No ☐ Yes - how many per day? ________

DO YOU EXERCISE? ☐ No ☐ Yes (what forms and how often): ______________

WHAT IS YOUR MAJOR COMPLAINT?

____

____

DATE PROBLEM BEGAN: ______________

MAIN REASON FOR CONSULTING OFFICE:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

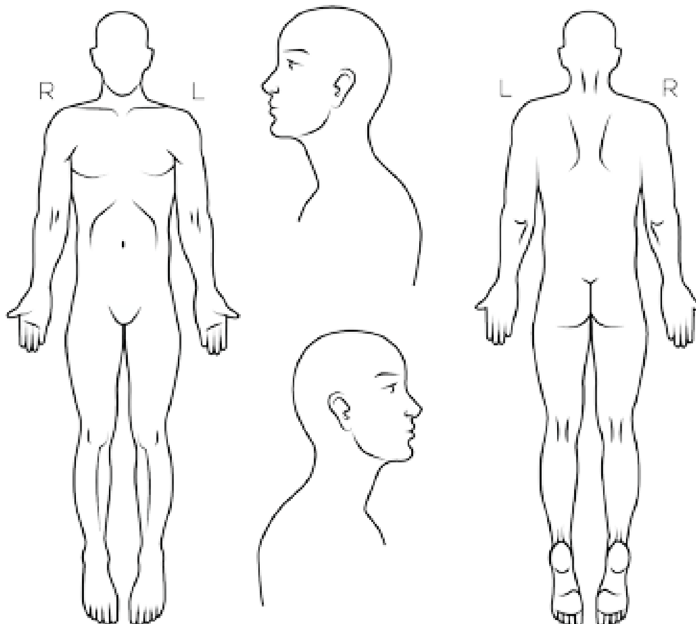
HOW IS YOUR CONDITION CHANGING?

☐ Getting Better ☐ Getting Worse ☐ Not Changing

HAVE YOU HAD THIS CONDITION IN THE PAST?

☐ NO ☐ YES

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

☐ Sharp	☐ Shooting	☐ Stabbing
☐ Dull	☐ Tingling	☐ Throbbing
☐ Numb	☐ Radiating Pain	☐ Other:
☐ Burning	☐ Tightness	________

PLEASE RATE YOUR PAIN ON A SCALE FROM 1 to 10

(0 = no pain and 10 = excruciating pain)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES SUCH AS WORKING OR DRIVING? (0 = no effect and 10 = no possible activities)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION (working, exercise, etc.)? ______________

____

WHAT MAKES YOUR PAIN BETTER? (ice, heat, massage, etc.)? ______________

____

HAVE YOU EVER HAD CHIROPRACTIC CARE? ☐ YES ☐ NO

WHEN? ______________ **WHERE?** ______________

WERE X-RAYS TAKEN? ☐ YES ☐ NO **WHEN WAS YOUR LAST ADJUSTMENT?** ______________

6320 Commodore Sloat Dr, Los Angeles, CA 90048 (323) 935-3420 www.ProExPerformance.com