

CRABB CHIROPRACTIC CLINIC-

Patient Case History

Name : _____ Patient No. _____ Date: _____

Is your problem due to a recent automobile accident or work related injury? auto work neither

Present Complaint (major) : _____

Other: _____

What exactly is the problem? _____

When did the problem occur? _____

How did you injure yourself? _____

Describe the pain: circle - constant / frequent/ intermittent

Rate Intensity of pain: **circle -** 1 2 3 4 5 6 7 8 9 10 (Mild 1-4 Minimal effect on daily activities.) (Moderate 5-7 Some restriction of daily activities and possible loss of work.) (Severe 8-10 Cannot get relief from pain, effects most daily activities and possible loss of work.)

How does it affect your daily activities? _____

What makes the pain better? _____

What makes the pain worse? _____

Have you tried any home remedies? _____

Have you seen any other health care professionals? _____

Have you taken any medications? _____

Past History

Have you ever experienced this problem before? When? Was treatment provided? _____

Accidents _____

Surgeries _____

Medications _____

Hospitalizations _____

Social History

Smoker: yes / no Packs/day _____

Drink _____ cups of coffee per day

Drink _____ alcoholic drinks per day

Commute _____ minutes to work

Work _____ hours per week (average)

Exercise _____ hours per week

Patient Signature

Date