CRABB CHIROPRACTIC CLINIC **Patient Case History**

Name:_____ **Patient No.**_____ **Date:**_____

What problem(s) or symptom(s) brought you here?

_____

_____

When did you notice problem(s) or symptom(s) became more frequent?_____

How did you injure or over strain yourself?_____

Describe the pain: Please circle what you have. constant / frequent/ intermittent

Rate intensity of pain: Please check the box what you have. ☐ 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 activities

Which daily activities are difficult to do ?_____

What makes the pain better ? _____

What makes the pain worse? _____

Have you taken any medications? _____

Are you receiving care from other health professionals(specialty)? ___no ___yes(please name below)

Past History _____

Have you ever had chiropractic care before? ___no ___yes Who?_____

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

_____

Accidents _____

Surgeries_____

Medications _____

Hospitalization: _____

Social History

Smoker: yes / no Packs/day ____ Commute _____ minutes to work

Drink _____ cups of coffee per day Work _____ hours per week (average)

Drink _____ alcoholic drinks per day Exercise _____ hours per week

What social activities do you enjoy ?

1) _____ *2)* _____ *3)* _____ *4)* _____ *5)* _____

What is your expectation from chiropractic treatment ?

Please circle what you want: Pain relief / stiffness relief /functional improvement/ other

_____

Patient signature Date