

Case History

1. Major complaints and symptoms _____

2. Date current symptoms began? ____/____/____ What do you believe caused this condition?

3. Quality of pain, check all that apply sharp dull ache numbness tingling

4. Has this happened before Yes No If yes, when _____

5. Does this interfere with your normal activities and/or work? Yes No

Any family history of this condition? Yes No

6. What helps your condition most? _____

7. What aggravates your condition? _____

8. Any work-related accidents in past 2 years Yes No

9. Any car accidents in past 4 years Yes No

10. Do you smoke? Yes No

11. Are you presently taking any nutritional supplements? Yes No

12. Have you had treatment by another doctor for this? Yes No M.D. D.O. D.C.

Name of doctor _____ Diagnosis _____

Length of time under doctor's care _____ Results _____

Surgery _____ Shots _____

Treatment _____ X-rays _____ Urinalysis _____ Blood test _____

Medications presently taking _____

Staff use: Initials _____