# CONFIDENTIAL CASE HISTORY

Sunrise Chiropractic
Wake up to better health

*Your answers will help us determine if our care can help you. If you need help with this form, please do not hesitate to ask us.*

## PERSONAL INFORMATION

DATE:_____

Name: _____ Gender: M / F

Email: _____ Date of Birth: day ____ mm ____ yr _____

Address: _____ Town: _____

Postal Code: _____ Phone: Home- _____ Work- _____

Cell - _____ Occupation: _____

Employer: _____ Hobbies: _____

Spouse/ Partner's Name: _____ Contact #: _____

Family Physician's Name: _____

Who referred you to our office? _____

## HEALTH INFORMATION

**Have you consulted a chiropractor previously? NO / YES Name: _____**

**When was your last visit? _____ What was the problem? _____**

**Were X-rays taken? YES / NO Have you consulted a health care professional for your current problem? YES / NO if yes, who?_____**

## REASON FOR CONSULTING OUR OFFICE

- ○ I have a specific health concern and require help only with this problem.
- ○ After my health concern has been relieved, I'm interested in strategies to ensure it does not return.
- ○ I have no symptoms and am interested in strategies to help me continue to feel well.

What is your main complaint? _____

How long have you had this? _____ Have you had this previously? YES / NO

What activities aggravate your condition? _____

What makes it feel better? _____

Is your condition getting worse? YES / NO Constant / Comes and goes / Getting better

If you have pain how would you describe it? Sharp / Dull / Heavy / Throbbing / Numb / Ache

Are you taking any prescribed or over the counter medication? YES / NO List: _____

_____

Have you consulted a medical doctor for this or any related problem? YES / NO List Doctor's Name and Diagnosis: _____

List surgeries, broken bones, and major illnesses? _____

_____

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Have you ever been in an auto accident? YES / NO if so: Past Year Past 5 Years Over 5 Years

Description of accident: _____

Do you have any allergies? YES / NO List: _____

Are you a smoker? YES / NO If Yes how much per day? _____

**Family History** (Circle) Do you have a family history of any of the following conditions?

Cancer Osteoporosis Arthritis Cardiovascular Disease Stroke Hypertension Diabetes

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**Please mark each item below for each condition you presently have or previously had:**

| **Muscle & Joint** | **Stress Symptoms** | **Females Only** |
|---|---|---|
| Back ache | Dizzy | Pregnant currently |
| Neck pain | Blurry vision | Irregular cycle |
| Arm/Hand Pain or Tingling | Sleep loss | Painful menstruation |
| Leg/Foot Pain | Depression | **Urinary** |
| Faulty posture | Decreased energy | Sense of urgency |
| Scoliosis | Loss of concentration | Blood in urine |
| **Respiratory** | **General Symptoms** | Painful urination |
| Asthma | Fainting | **Ears, Nose, Throat** |
| Chest pain | Convulsion | Sore throat |
| Chronic cough | Loss of balance | Tonsillitis |
| Shortness of breath | Tremors | Allergies |
| **Cardiovascular** | Colds | Sinus problems |
| High Blood Pressure | **Digestive** | Ear infections |
| Low Blood Pressure | Belching/gas | **Infections** |
| Previous heart attack | Stomach pain | AIDS/HIV |
| Chest pain | Constipation | TB |
| Racing heart | Heartburn | Hepatitis |
| Previous stroke | | |

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Have you ever had any diagnostic tests including X-rays, Ultrasounds, CT Scans, Bone Density Scans, MRI or other? Please indicate when and for what reason: _____

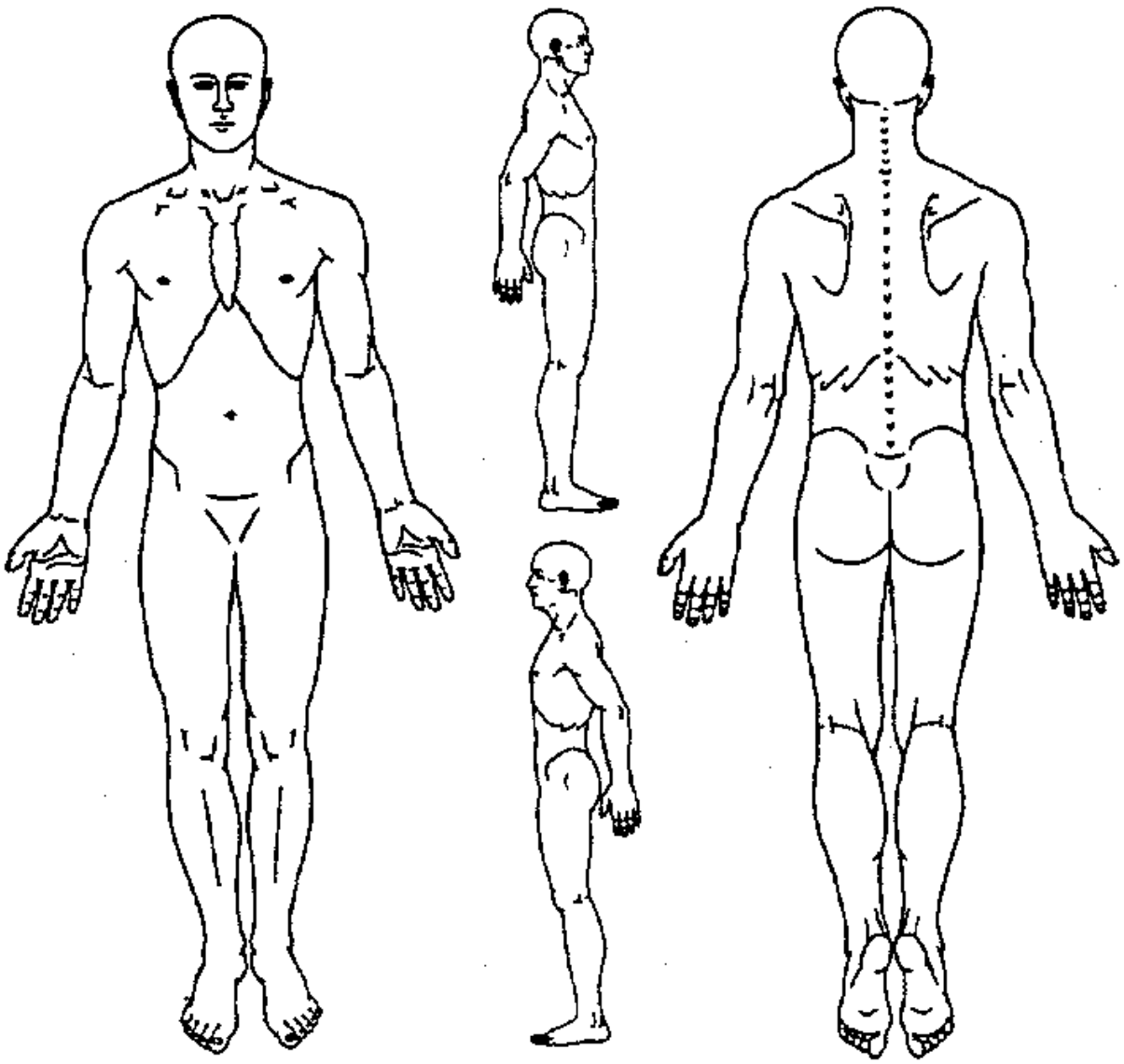
_____

Name:_____ Date:_____

# PAIN DIAGRAM

**On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.**

**Key**: **A** – ACHE **B** – BURNING **N** – NUMBNESS
**P** – PINS & NEEDLES **S** – STABBING **O** - OTHER



## PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain — Worst Possible Pain

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|