

# Maine Chiropractic Health Clinic

## Patient Case History

File # \_\_\_\_\_

Today's date \_\_\_\_\_ Referred by \_\_\_\_\_

Name \_\_\_\_\_ Social Security# \_\_\_\_\_

Address \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status: M S W D  Male  Female

Home Phone # \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Work Phone # \_\_\_\_\_ Ext. \_\_\_\_\_ Spouse's Work Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Insurance \_\_\_\_\_

Occupation \_\_\_\_\_ E-mail \_\_\_\_\_

Would you like to receive a subscription to a chiropractic newsletter by e-mail every two weeks at no charge?  Yes  No

Personal Injury  Work Injury  Auto Accident

**FOR OFFICE USE ONLY - PLEASE DO NOT WRITE BELOW**

## Case History

Reason for the consultation \_\_\_\_\_

When did it happen \_\_\_\_\_ Gradually or suddenly

How did it happen \_\_\_\_\_

Have you had a similar condition before \_\_\_\_\_ When \_\_\_\_\_

## Type of Pain

Where the pain originally started \_\_\_\_\_ left/right

Does it radiate \_\_\_\_\_

Constant \_\_\_\_\_  intermittent \_\_\_\_\_

Time of day (worst/better) \_\_\_\_\_

Does it affect your daily act. \_\_\_\_\_

Can you make it better \_\_\_\_\_

Does the pain change when:  sitting  standing  lying \_\_\_\_\_

Any repetitive movement at work \_\_\_\_\_

## Other Symptom Associated

Headache \_\_\_\_\_  Dizziness \_\_\_\_\_  GI problem \_\_\_\_\_

Recent fever/chill \_\_\_\_\_  Blurred vision \_\_\_\_\_  Pain at night \_\_\_\_\_

Recent weight loss \_\_\_\_\_  Arm/ leg weakness \_\_\_\_\_

Previous consult. Dr. \_\_\_\_\_, \_\_\_\_\_ Date \_\_\_\_\_ Diagnosis \_\_\_\_\_

Therapy followed \_\_\_\_\_ Result:  good  fair  poor  worst