HISTORY OF PRESENT ILLNESS

Case No. _____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ BIRTHDATE _____ AGE _____NUMBER OF CHILDREN _____

CITY _____STATE _____ ZIP _____ DL# _____ SS# _____

OCCUPATION _____

EMPLOYER _____

HOME PHONE _____ WK _____

SPOUSE NAME _____

SPOUSES OCCUPATION _____

EMPLOYER _____

CELL PHONE EMAIL REFERRED BY

What is your chief complaint? _____

Describe how it feels: _____ What caused this problem? _____

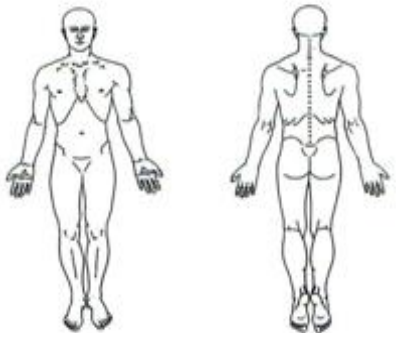
How long have you had this condition (date)? _____ Have you had this or a similar condition in the past? _____

What makes this condition better or worse? _____ At worst my complaint is (**circle**) Mild Uncomfortable Distressing Intense Unbearable

Is your problem constant ☐ or comes and goes ☐ Is it getting Better ☐ Same ☐ or Worse ☐ **Did your accident occur while at work? Yes ☐ No ☐**

CHECK ALL THE SYMPTOMS YOU HAVE:

☐ Headache	☐ Neck pain	☐ Low back pain
☐ Dizzy spells	☐ Tightness in neck & shoulders	☐ Leg pain
☐ Buzzing/Ringing in the ears	☐ Head feels heavy	☐ Groin pain
☐ Blurred vision	☐ Loss of balance	☐ Leg numbness
☐ Nervousness	☐ Pins & Needles in the arms	☐ Leg pins & needles
☐ Depression	☐ Numbness in arm or hand	☐ Constipation
☐ Memory/Concentration problems	☐ Chest pain	☐ Diarrhea
☐ Crying and/or Anger spells	☐ Pain between the shoulder blades	☐ Pain on bearing down
☐ Sleeping problems	☐ Abdominal pain	☐ Difficulty in rising up
☐ Fatigue	☐ Urination problems	☐ Limping
☐ Blood pressure problems	☐ Diabetes	☐ Chance of being pregnant



PLEASE MARK THIS DRAWING
N = Numbness **P** = Pins & needles
A = Ache **B** = Burning **S** = Stabbing

Check the Activities of Daily Living that are affected by this condition:

Bending	☐
Care – Infirm Family	☐
Carrying Groceries	☐
Change Position Sitting to Standing	☐
Climbing Stairs	☐
Driving	☐
Extended Computer Use	☐
Feeding	☐
Household Chores	☐
Kneeling	☐
Lift Children	☐
Lifting	☐
Pet Care	☐
Reading and Concentration	☐
Self Care – Bathing	☐
Self Care – Dressing	☐
Self Care – Shaving	☐
Sexual Activities	☐
Sleep	☐
Static Sitting	☐
Static Standing	☐
Walking	☐
Yard Work	☐

Doctors Notes:

If your condition was treated before, what was done? _____

Name of Doctors: _____

Have you ever had surgery or been hospitalized? Yes ☐ No ☐

List Surgeries: _____

Have you ever had Chiropractic care before? Yes ☐ No ☐

Name of Doctor _____ Date _____

Medications you now take: _____

Accidents, falls and injuries: _____

SIGN ✗ Date