

KATZ CHIROPRACTIC & REHABILITATION CLINIC

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Office 303-938-9070 ~ Fax 303-938-9170

CHIROPRACTIC CASE HISTORY

Name _____ M _____ F _____ Date _____

Date of Birth _____ Age _____

Have you ever received Chiropractic Care? Y _____ N _____ If Yes, when? _____

Were you injured in an automobile collision? Y _____ N _____ If yes, what was the date of your accident? _____

Referred by: _____

1. Primary reasons for seeking chiropractic care:

Primary Reason: _____

Secondary Reason/Contributing Factors _____

2. Chief Complaint:

Location of Complaint _____

When and how did the complaint begin? _____

Please circle the quality of the complaint/pain: Dull aching sharp shooting burning throbbing deep nagging
Other, please describe _____

Does this complaint/pain travel (shoot) to any areas of your body? Y ___ N ___ Where? _____

Grade Intensity (no complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible complaint/pain imaginable)

How frequent is complaint present? _____ How long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatment, medications, surgery, or care you have sought for your complaint?

4. Past Health History:

A. Previous illnesses you have had _____

B. Previous injury or trauma _____

Have you ever broken any bones? _____

Allergies: _____

Medications

Reason for taking

Surgeries/Date:

Types of Surgery

Females/Pregnancies and Outcome(s)
Date of Delivery: _____

Outcome

What was the date of your last menstrual period? _____

5. Family Health History: Associated health problems of relatives: _____

6. Social and Occupational History:

Level of Education High School Some College College Graduate Post Graduate Studies

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Lifestyle (hobbies, level of exercise, diet, alcohol, tobacco and drug use: _____

I have read the information above and certify it to be true and correct to the best of my knowledge, and hereby authorize Katz Chiropractic to provide me with chiropractic care, in accordance with the State of Colorado's statutes.

Patient Signature _____ Date _____

Patient or Guardian Signature _____ Date _____