MOSKAL CHIROPRACTIC

Patient Case History

Name_____ _____ Date_____

Address_____City_____State_____Zip_____

Date of Birth_____(Age_____) Phone (hm)_____(cell)_____

Sex: Male Female

Employed by_____ Occupation_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

How were you referred to our office?_____

List ALL Past Medical History:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain
☐ Depression ☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting
☐ Fatigue ☐ Foot Pain ☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems
☐ Hepatitis ☐ High Blood Pressure ☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain
☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain ☐ Minor Heart Problems ☐ Multiple Sclerosis
☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's ☐ Polio ☐ Prostate Problems
☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain
☐ Stroke/Heart Attack ☐ Other:_____

List any Medications you are taking:

☐ Anxiety ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin ☐ Birth Control ☐ Allergy ☐ Seizures
☐ Other:_____

List any Surgeries:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist
☐ Other:_____

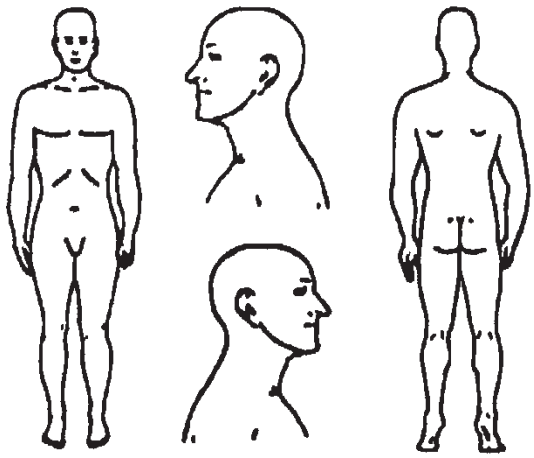
List your Family History:

	Diabetes	Heart	Kidney	Cancer	Back	Other
Mother	☐	☐	☐	☐	☐	☐_____
Father	☐	☐	☐	☐	☐	☐_____
Brother, # of_____	☐	☐	☐	☐	☐	☐_____
Sister, # of_____	☐	☐	☐	☐	☐	☐_____

MOSKAL CHIROPRACTIC

Patient Case History

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



What is your major symptom?_____ Date began?_____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? ☐ Yes ☐ No

How often do you experience your symptoms?

☐ Constantly (76 – 100% of the day) ☐ Frequently (51 – 75% of the day)

☐ Occasionally (26 – 50% of the day) ☐ Intermittently (0 – 25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling

☐ Cramping ☐ Stabbing ☐ Throbbing ☐ Other:_____

Does your pain radiate or travel to any other area? ☐ Yes ☐ No Where? _____

Please rate your pain on a scale of 1 – 10 (0 = No pain; 10 = Excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What makes your condition worse (working, exercise, etc.)?_____

What makes your condition better (ice, heat, massage, etc.)?_____

Have you had any auto or other accidents? ☐ No ☐ Yes

Describe:_____

_____

List any other symptoms:_____

Do you Smoke? ☐ No ☐ Yes