

Patriot Chiropractic Center
3195 Old Lee Hwy., Ste 22C
Fairfax, VA 22030
(703)385-7007 Fax (703)385-4384
patriotchiropractic@verizon.net

CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Date _____

Have you ever received Chiropractic Care? Yes No

If yes, please explain: _____

Symptoms and Present State of Health:

Primary Complaint: _____

Pain or Problem started on: _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

Does this pain shoot, radiate, or travel in your body? Yes No

Where? _____

Are you experiencing numbness or tingling in any area of your body? Yes No

Where? _____

Since it began, is it: Same Better Worst

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with...

Work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition progressively getting worse? _____

Other Doctors seen for this condition: _____

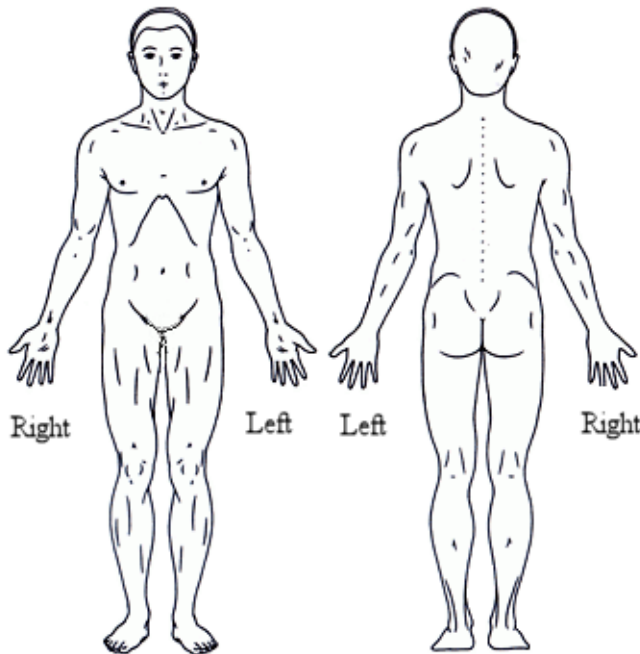
Any home remedies? _____

Please circle your pain level: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Have you had diagnostic studies performed (X-rays, MRI, etc..)? _____

If yes, what area of the body and when were they taken? _____

Please mark where pains
are on figures:



Secondary Complaint: _____

Pain or Problem started on: _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

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Where? _____

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Since it began, is it: Same Better Worst

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Is this condition worse during certain times of the day? _____

Is this condition interfering with...

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Is this condition progressively getting worse? _____

Other Doctors seen for this condition: _____

Please mark any of the following conditions or symptoms that you have now or have experienced:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sinus Allergies | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Hardening of the Arteries | <input type="checkbox"/> Heart or Blood Vessel Diseases | <input type="checkbox"/> Bone Spurs on the Neck Bones |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Sudden Collapse | <input type="checkbox"/> Sinus Headaches |

Are you under medical care for any condition, Please list:

What medications are you taking? _____

How long? _____

Are you taking any blood thinning medications? _____

Are you taking any vitamins/supplements? _____

How long? _____

Have you had surgery? _____ Type of surgery _____

When? _____

What side effects have you experienced from the drugs and surgery? _____

Do you have a pacemaker or other electrically implanted device? _____

Were you ever a smoker? From _____ to _____ Packs per day/week? _____

Family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Females Only:

Date last Menstrual Period began on _____ Are you possibly pregnant? Yes No
Do you have children? _____ How many pregnancies experienced? _____
Have you ever taken oral contraceptives? Yes No From (Age) _____ to _____

All Patients:

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____