Patriot Chiropractic Center
3915 Old Lee Hwy, Ste. 22C
Fairfax, VA 22030
(703)385-7007 Fax (703)385-4384
patriotchiropractic@verizon.net

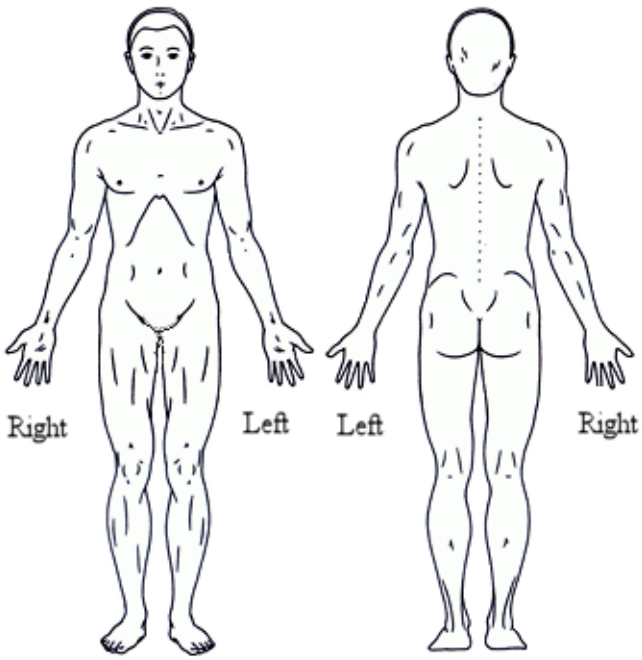
CONFIDENTIAL PATIENT CASE HISTORY

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_____
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 yourcondition/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:_____

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

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

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_____