Chiropractic Case History/Patient Information

Date___________________________ Patient ID#______________________________

Name____ Social Security # ________________________

Home Phone_______________________ Cell Phone ________________________Cell Carrier ___________________

Address ____________________________________ City__________________ State ________ Zip_________

Email address ____

Date of Birth_______________ Marital Status: M S W D How many children? _______ Race______________

Optional to Answer

Race ☐ I do not wish to provide this information

☐ White

☐ Black or African American

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or Other Pacific Islander

Ethnicity ☐ I do not wish to provide this information.

☐ Hispanic or Latino

☐ Non-Hispanic or Non-Latino

☐ Other ________________________

Occupation ___________________________________Employer _________________________________

Employer's Address____

Employer's Address ____ Office Phone_________________

Spouse ____________ Occupation _________________Employer __________________________________

Name of Nearest Relative________________________Address___________________Phone _________

How were you referred to our office? ____

Family Medical Doctor ____

Purpose of this appointment ____

Date symptoms appeared or accident happened ____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe: ________

____

Days lost from work ____________________

Date of last physical examination ______________ What surgeries have you had? (Include dates)_________

____

Serious illnesses (include dates)____

____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe: ____

____

Are you currently taking any medications?

☐ Not currently prescribed any medications

☐ Yes What? ______________________________ _______ mg For What Condition? ____________________

What? ______________________________ _______ mg For What Condition? ____________________

What? ______________________________ _______ mg For What Condition? ____________________

Do you have any medication allergies?

☐ No known medication allergies

☐ Yes. What? ____

Smoking Status?

☐ Current every day smoker ☐ Former smoker ☐ Current some day smoker ☐ Never smoker

Women Are you pregnant? ☐ Yes ☐ No ☐ Uncertain

Are you stressed? ❑ Yes ❑ No

Do you think your stress is causing/creating your pain? ❑ Yes ❑ No

What time of day is your pain worse? ______________________________

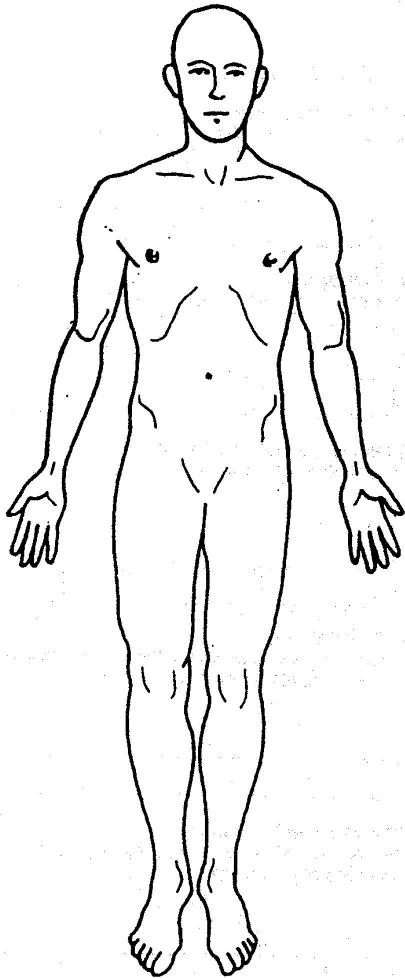
TELL US WHERE YOU HURT.

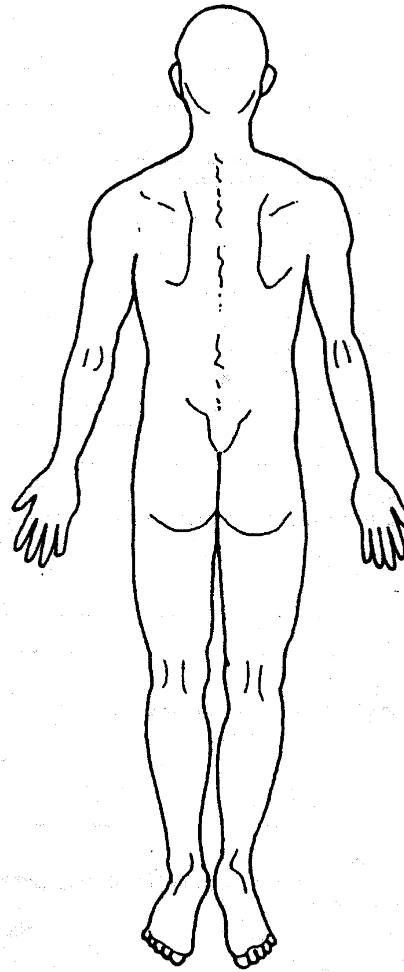
Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels.

Pain Scale

Min 0-1-2-3-4-5-6-7-8-9-10 Max





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Patient/Guardian/Financially Responsible Person Signature Date

Hall Chiropractic & Wellness Center

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