CASE HISTORY

McDonald Chiropractic 943 S Gilbert Street Iowa City, IA 52240

Patient Name_____ Today's Date_____
First MI Last

Address_____ City_____ State_____ Zip_____

SSN_____ Birth date_____ Age_____ ☐ Male ☐ Female

Home phone #_____ Work Phone #_____ Cell#_____

Email address_____

Check appropriate box: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other_____

Employer_____ Occupation_____

Spouse's name_____ His/Her employer_____

Referred by ☐ Internet /Website _____ ☐ Insurance ☐ Other _____

Person to contact in case of emergency _____ Relationship_____ Phone_____

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Reason for this visit:_____

When did you first notice these symptoms?_____Have you had this condition in the past? ☐ No ☐ Yes

Current symptoms are the result of: ☐ work ☐ sports ☐ auto ☐ injury/accident ☐ chronic ☐ other _____

Is this condition: ☐ improving ☐ worsening ☐ the same For how long? _____

How often do you experience your symptoms? ☐ constantly ☐ frequently ☐ occasionally ☐ intermittently

Is this condition interfering with your ☐ work ☐ sleep ☐ daily routine

Which activities are difficult to perform? ☐ sitting ☐ standing ☐ walking ☐ bending ☐ lying down ☐ other _____

Have you seen anyone else for this condition? ☐ No ☐ Yes, who? _____

What was the diagnosis? _____

Treatment given: ☐ chiropractic care ☐ medication ☐ surgery ☐ physical therapy ☐ other _____

Have you been to a chiropractor before? ☐ No ☐ Yes, when? _____

Name of previous chiropractor? _____ Were x-rays taken? ☐ Yes ☐ No

List surgical operations and years :_____

Do you smoke? ☐ No ☐ Yes How much? _____

For women only: Are you pregnant? ☐ No ☐ Yes If yes, date of last menstrual cycle?_____

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Please check the following conditions you have had.

☐ AIDS/HIV
☐ Anemia
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Polio
☐ Epilepsy
☐ Fractures
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Chicken Pox
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Stroke
☐ Tumors. Growths
☐ Cancer
☐ Herniated Disc
☐ Rheumatoid Arthritis
☐ Appendicitis
☐ Arthritis
☐ Back Trouble
☐ Hernia
☐ Prostate Trouble
☐ Diabetes
☐ High Blood Pressure
☐ Migraine Headaches
☐ Heart Trouble
☐ Prosthesis
☐ Other _____

Family History– Has any blood relative had any of the following: (check if yes, leave blank if uncertain)

	Relationship		Relationship
☐ Back Problems	_____	☐ Heart Disease	_____
☐ Cancer	_____	☐ Migraine Headaches	_____
☐ Diabetes	_____	☐ Stroke	_____
☐ Epilepsy	_____	☐ Other	_____

Please check any of the symptoms listed that currently apply to you.

- ☐ Good general health
- ☐ Recent weight change
- ☐ Fever
- ☐ Headaches
- ☐ Nerve Pain
- ☐ Numbness
- ☐ Weakness
- ☐ Skin Changes
- ☐ Night Pain
- ☐ Vision Problems
- ☐ Eye Pain
- ☐ Sinus Problems
- ☐ Heart Trouble
- ☐ Chest pain or angina
- ☐ Palpitation
- ☐ Swelling of feet, ankles, or hands
- ☐ Leg Cramps
- ☐ Throbbing Pain
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Frequent Urination
- ☐ Kidney Infection/Stones
- ☐ Burning or painful urination
- ☐ Increase in thirst
- ☐ Heat/Cold Intolerance
- ☐ Skin Rash
- ☐ Joint Pain
- ☐ Joint stiffness/swelling
- ☐ Cold Extremities
- ☐ Difficulty Walking
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Painful Tail Bone
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Frequent Headaches
- ☐ Light Headed/Dizzy
- ☐ Convulsions/Seizures
- ☐ Tremors
- ☐ Paralysis
- ☐ Pain between shoulders

Pain or numbness in:

- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Other _____

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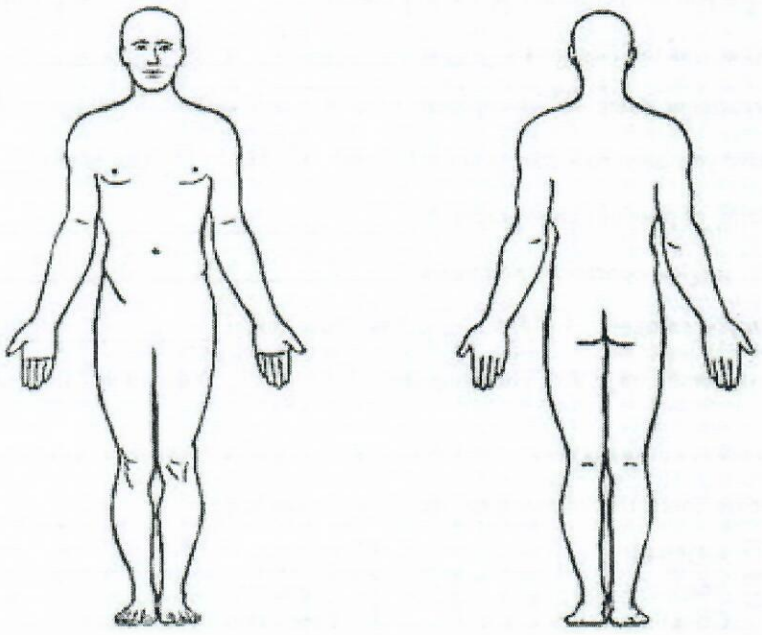
List major complaints and circle the intensity of the pain on a scale of 1 to 10 for each complaint.

	LESS ←								→ MORE
Primary complaint: _____	1	2	3	4	5	6	7	8	9	10
Secondary complaint: _____	1	2	3	4	5	6	7	8	9	10
Other complaint: _____	1	2	3	4	5	6	7	8	9	10

Please mark on the drawings , the area (s) and type of pain/sensation that you are feeling.

Numbness.....N
Pain.....P
Tingling.....T
Ache.....A



I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date