Pro Health CHIROPRACTIC & MORE

Case History Update

1777 W. Main Street
Sun Prairie, WI 53590
(608) 318-2410

Name:		Today's Date:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Email:

Insurance Information On File

Office Information

☐Posture
☐Room ☐Chairside
RE for: ☐New Injury (Known) ☐Insurance ☐Reactivation

Current Health Condition

Areas of Complaint or Reason(s) you're being Seen Today:

Are your symptoms	☐New ☐ Getting Better ☐Getting Worse ☐Same/No Change
What percentage of relief have you received since you first came in?	☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80 % ☐90% ☐100%
Describe How it Feels	☐Sharp ☐Dull ☐Throbbing ☐Stiffness ☐Burning ☐Numb ☐Tingling ☐Ache ☐Weak
Pain Level Today	0 1 2 3 4 5 6 7 8 9 10
Pain At it's Worst	0 1 2 3 4 5 6 7 8 9 10
Pain At it's Best	0 1 2 3 4 5 6 7 8 9 10
How often Do you Have Symptoms?	☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day
When are they worst?	☐Morning ☐Afternoon ☐Evening ☐Intermittent ☐Constant
When did symptoms start?	
When did they get worse?	
Has this happened before?	☐No ☐Yes If yes, When?:
When did you have them last?	☐No ☐Yes If yes, When?:
Did a specific injury occur?	☐No ☐Yes If yes, When?:
Did a specific accident occur?	☐No ☐Yes If yes, Explain:
Is this related to a Work Injury?	☐No ☐Yes See Additional Paperwork
Is this related to an Auto Accident?	☐No ☐Yes See Additional Paperwork
Does anything make it better?	☐No ☐Yes If yes, What?:
Does anything make it worse?	☐No ☐Yes If yes, What?:
What Daily Activities does this condition affect? (Circle All that apply)	☐Bending ☐Changing Sit to Stand ☐Child Care ☐Climbing Stairs ☐Computer Use ☐Pet Care ☐Driving ☐Bathing ☐Kneeling ☐Sleep ☐Sitting ☐Standing ☐Housework ☐Reading/Concentration ☐Yard Work ☐Exercise ☐Walking ☐Running ☐Other (Please List)_____

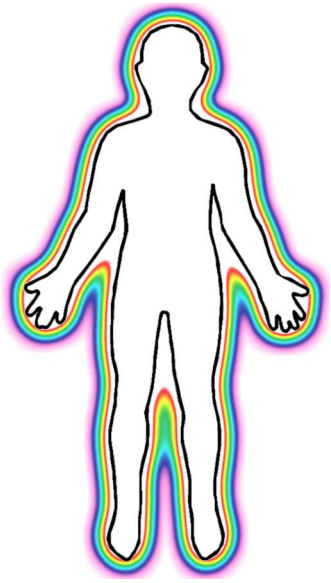
Medication Update	Please list all medications & Doses you are currently taking or attach a medication list to this form.
Supplement Update	If you are currently taking any supplements – please list below or attach a list:

What would you love to be doing that you are unable to do now?	
What would you love to be doing better that you can already do now?	

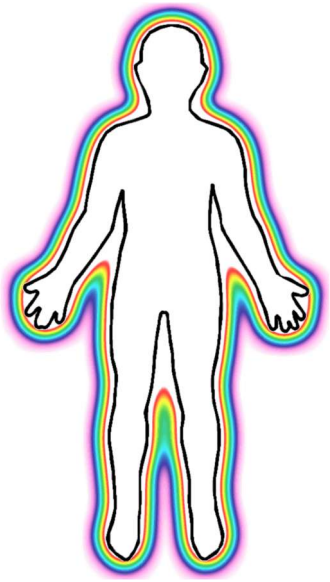
Signature:	Date:

Please Circle Areas of Complaint. Use the following letters to describe your symptoms:

S – Stiffness
B – Burning
N – Numbness
P – Sharp Pain
T – Tingling
D – Dull Pain



Front



Back