Back 2 Health Chiropractic, LLC
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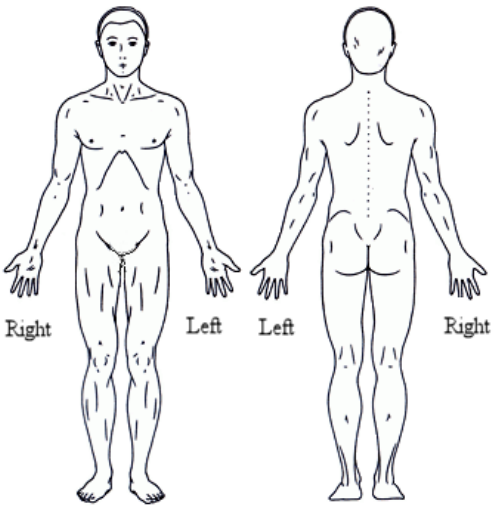
back2healthidaho.com

CASE HISTORY

Name _____Age _____Date _____
Address _____City _____ State_____ Zip_____
Phone (Home) _____Date of Birth _____ Sex: M F Marital Status: S M D W P
Social Security # _____Occupation/Employer _____Phone (Work)_____
Whom can we thank for referring you?_____
Emergency Contact_____Relation_____
Insurance Company_____
Insured's Name _____ Insured's Date of Birth _____
Spouse's Name _____Spouse's Occupation _____Spouse's Phone (Work)_____
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

HEALTH REPORT:

Reason for seeking care: _____
Have you seen any other Doctors for this condition? __Yes __No If yes, who_____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
Have you received chiropractic treatment previously? __ Yes __ No If yes, explain: _____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____
Are you currently taking medication? __ Yes __ No list medications: _____
_____
List the conditions you are taking medications for: _____
List the approximate dates of any surgery or treated conditions:_____
_____
Family History: Health conditions, age of death and cause of death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____
Do you smoke Y/N ____ •Alcohol Y/N __Daily __Weekly __Social Occasions •Caffeinated drinks per day _____
Do you take Vitamins/Supplements Y/N If yes, type and how often _____
Hobbies/Recreational Activities:_____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel pain.

Numbness	* * *
Dull/Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins/Needles	+ + +
Other _____	^ ^ ^

What % of time when awake do you feel this pain? 0%-100%_____
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N If yes circle one:
Morning Afternoon Evening Night Unaffected by time of day

Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse? Y/N
Does your condition radiate/travel to other parts of your body? Y/N If yes, where?_____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
_ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergies
_____

FOR WOMEN ONLY
__ Birth Control
_____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain

Pregnant at this Time Y/N

Pregnancies _____

Date/Dates of delivery_____

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**. Our policy requires payment in full of all services rendered at the time of visit, unless other arrangements have been made with the doctor.** I agree to allow this office to examine me further for evaluation, diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Patient Signature_____Date_____

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