Northern Family Chiropractic

13968 Cypress Drive - Suite 1B
Baxter, MN 56425
218-822-3855 / (fax) 218-822-3854

Chiropractic Case History

Name_____ Sex M F Date_____

Address_____ City_____ State_____ Zip_____

H. Phone(____)_____ W. Phone(____)_____ Date of Birth_____ Age_____

Referred by_____ Social Security Number_____

Occupation_____ Employer_____

Primary reasons for seeking chiropractic care:

Chief complaint:_____

Location of complaint:_____

When and how did complaint begin?_____

Please circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Yes No Where?_____

Do you have any numbness or tingling in your body? Yes No Where?_____

Grade of intensity/severity (0=no pain 10=worst possible pain) 0 1 2 3 4 5 6 7 8 9 10

How frequent is complaint present/how long does it last?_____

What aggravates the complaint/pain?_____

What makes the complaint/pain better?_____

Have you ever received chiropractic care? Yes No If yes, when and by whom?_____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:_____

_____

Past Health History:

Previous illnesses you've had in your life:_____

_____

Previous injury or trauma:_____

_____

Have you ever broken any bones? Yes No If yes, which bones and when? _____

_____

Allergies:_____

Medications you are presently taking: Reason for taking:

_____ _____

_____ _____

Vitamins/Supplements you are presently taking: Reason for taking:

_____ _____

_____ _____

Previous Surgeries: Date of Surgery:

_____ _____

_____ _____

Pregnancies and Date of Delivery: C-Section or Vaginal & Name of Child

_____ _____

_____ _____

_____ _____

What was the date of the beginning of your last menstrual period?_____

Family Health History:

Is there a history of your chief complaint within your family?_____

_____

Associated health problems of relatives?_____

Deaths in immediate family:

Cause of parents or siblings death: Age at death:

_____ _____

_____ _____

Social and Occupational History:

Job description:_____ How long have you been employed at this job?_____

Recreational activities/hobbies:_____

Do you exercise regularly? Yes No If yes, what do you do?_____

Do you typically eat a healthy diet?_____

Do you smoke? Y N How many per day? Do you drink alcohol? Y N How many drinks per week?_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statues.

Signature:_____ Date_____