CHARLOTTE WELLNESS CENTER
PATIENT CASE HISTORY

Date: ______________

Name: ____ MR#_________

Address: ____

City: __________________________ State: ____________ Zip: ________________________

Home Phone: ______-______-_______Work Phone: ______-______-_______ Cell Phone: ______-______-___________

Email Address: _________________________________ Occupation: ________________Employer:_________________

Date of Birth: _______________________ Social Security #: _______-______-_______ Gender: Male - Female

Spouses Name: ______________________ Spouses Date of Birth: _________ Spouse's Employer: _________________

List any **Allergies**:

• Animals • Aspirin • Bees • Chocolate • Dairy • Dust • Eggs • Latex • Molds • Penicillin • Ragweed/Pollen
• Rubber • Seasonal Allergies • Shellfish • Soaps • Wheat • X-Ray Dye • Other: ___________________________

List any **Surgeries**:

• Back • Brain • Elbow • Foot • Hip • Knee • Neck • Neurological • Shoulder • Wrist • Other: ______________

List **ALL Past Medical History** conditions:

• Ankle Pain • Arm Pain • Arthritis • Asthma • Back Pain • Broken Bones • **Cancer** • Chest Pain • Depression
• **Diabetes** • Dizziness • Elbow Pain • Epilepsy • Eye/Vision Problems • Fainting • Fatigue • Foot Pain
• Genetic Spinal Condition • Hand Pain • Headaches • Hearing Problems • Hepatitis • High Blood Pressure
• Hip Pain • HIV • Jaw Pain • Joint Stiffness • Knee Pain • Leg Pain • Menstrual Problems • Mid-Back Pain
• Minor Heart Problem • Multiple Sclerosis • Neck Pain • Neurological Problems • Pacemaker • Parkinson's
• Polio • Prostate Problems • Shoulder Pain • Significant Weight Change • Spinal Cord Injury • Sprain/Strain
• Stroke/Heart Attack • Gall Bladder • Seizures • Tumors • **Rheumatoid Arthritis** • **Osteoarthritis**
• **Head Problems** • Other: ____

List Type of **Medications** you are taking:

• Anxiety • Muscle Relaxors • Pain Killers • Insulin • Birth control • Cardiovascular • Allergy • Seizure
• Names of medication(s): ____
• Other: ____

List your **Family History**:

• Arthritis • Asthma • Back Pain • Cancer • Depression • Diabetes • Epilepsy • Genetic Spinal Condition
• High Blood Pressure • Heart Problems • Multiple Sclerosis • Neurological Problems • Parkinson's • Polio
• Prostate Problems • Stroke/Heart Attack • Other: ____

Have you had any auto or other accidents? • No zYes

Describe: ____

Patient: ____ MR#:_______ Gender: M or F DATE: ___________

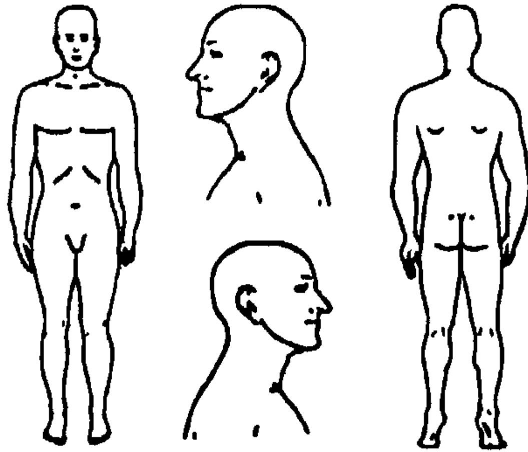
Date of last physical examination: _________________ Do you smoke? • No zYes

Do you drink alcohol? • No zYes - how many per day? _________________

Do you drink caffeine? • No zYes - how many per day? _________________

Do you exercise? • No zYes (what forms and how often): ______________________________

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- z Become pain free
- z Explanation of my condition
- z Learn how to care for my condition
- z Reduce symptoms
- z Resume normal activity level

Use the letters on diagram to represent <u>what</u> type of pain

A. Aching
B. Burning Sensation
C. Cramping
D. Dull Throbbing
M. Muscle Spasm
N. Numbness
S. Sharp
T. Tingling

What is your **MAJOR** complaint? ______________________ Date problem began? ______________

How did this problem begin (falling, lifting, etc.)? ______________________________

How is your condition changing? • GETTING BETTER • GETTING WORSE • NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

• Constantly (76-100% of the day) • Frequently (51-75% of the day)

• Occasionally (26-50% of the day) • Intermittently (0-25% of the day)

Describe the nature of your symptoms: • Sharp • Dull • Numb • Burning • Shooting • Tingling • Radiating Pain • Tightness • Stabbing • Throbbing • Other: ______________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

• 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

What activities aggravate your condition (working, exercise, etc)? ______________________________

What makes your pain better (ice, heat, massage, etc)? ______________________________

Patient: ______________________________ MR#:_______ Gender: M or F DATE: ___________

What is your **SECOND** complaint? ______________________ Date problem began? ______________

How did this problem begin (falling, lifting, etc.)? ______________________________

How is your condition changing? • GETTING BETTER • GETTING WORSE • NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

• Constantly (76-100% of the day) • Frequently (51-75% of the day)
• Occasionally (26-50% of the day) • Intermittently (0-25% of the day)

Describe the nature of your symptoms: • Sharp • Dull • Numb • Burning • Shooting • Tingling • Radiating Pain
• Tightness • Stabbing • Throbbing • Other: ______________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
• 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10= no possible activities) • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

What activities aggravate your condition (working, exercise, etc)? ______________________________

What makes your pain better (ice, heat, massage, etc)? ______________________________

What is your **THIRD** complaint? ______________________________Date problem began?
____

How did this problem begin (falling, lifting, etc.)? ______________________________

How is your condition changing? • GETTING BETTER • GETTING WORSE • NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?
• Constantly (76-100% of the day) • Frequently (51-75% of the day)
• Occasionally (26-50% of the day) • Intermittently (0-25% of the day)

Describe the nature of your symptoms: • Sharp • Dull • Numb • Burning • Shooting • Tingling • Radiating Pain
• Tightness • Stabbing • Throbbing • Other: ______________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
• 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10= no possible activities) • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

What activities aggravate your condition (working, exercise, etc)? ______________________________

What makes your pain better (ice, heat, massage, etc)? ______________________________

Have you ever had chiropractic care: • Yes • No

When? ________________ Why? ______________________________

Where? ______________________________

Were X-rays taken? • Yes • No

When was your last adjustment? ________________