Crestline Chiropractic Clinic
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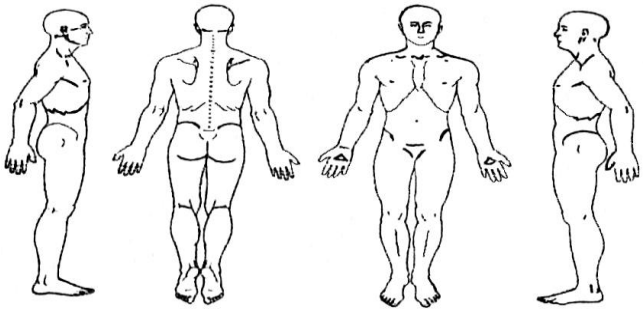
CASE HISTORY

Patient's Name: _____ Date: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal – Severe)	Frequency (% of week) (Occasional – Constant)
a._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Are you pregnant or is there a possibility you may be pregnant? _____ No _____ Yes ____ Uncertain
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____
18. Past Health History? _____
19. Family History? (Cancer, Diabetes, Etc.)_____
20. Have you ever been to a Chiropractor before? _____ No _____Yes. If Yes, who and when?_____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____