Maine Chiropractic Health Clinic

Patient Case History File # ____________________

Today's date ____________________ Referred by ____________________

Name ____________________ Social Security# ____________________

Address ____________________ Birthday ____________________ Age ________

City ____________________ State _____ Zip ______ Marital Status: M S W D ☐ Male ☐ Female

Home Phone # ____________________ Spouse's Name ____________________

Work Phone # ____________________ Ext. ____ Spouse's Work Phone # ____________________

Employer ____________________ Insurance ____________________

Occupation ____________________ E-mail ____________________

Would you like to receive a subscription to a chiropractic newsletter by e-mail every two weeks at no charge? ☐ Yes ☐ No

☐ Personal Injury ☐ Work Injury ☐ Auto Accident

FOR OFFICE USE ONLY - PLEASE DO NOT WRITE BELOW

Case History

Reason for the consultation ____________________

When did it happen ____________________ Gradually or suddenly

How did it happen ____________________

Have you had a similar condition before ____________________ When ____________________

Type of Pain

Where the pain originally started ____________________ left/right

Does it radiate ____________________

☐ Constant ____________________ ☐ intermittent ____________________

Time of day (worst/better) ____________________

Does it affect your daily act. ____________________

Can you make it better ____________________

Does the pain change when: ☐ sitting ☐ standing ☐ lying ____________________

Any repetitive movement at work ____________________

Other Symptom Associated

☐ Headache ____________ ☐ Dizziness ____________ ☐ GI problem ____________

☐ Recent fever/chill ____________ ☐ Blurred vision ____________ ☐ Pain at nignt ____________

☐ Recent weight loss ____________ ☐ Arm/ leg weakness ____________

Previous consult. Dr. ____________________ , ___ Date ____________ Diagnosis ____________

Therapy followed ____________________ Result: ☐ good ☐ fair ☐ poor ☐ worst