

FORME Medical & Rehab. and Kirk Chiropractic

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CASE HISTORY

Name: _____ Age _____ Date _____

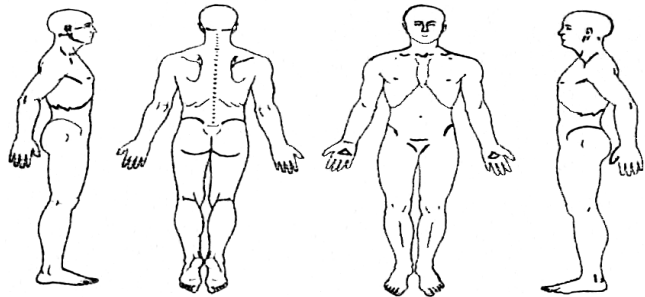
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					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

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. Is this condition interfering with Work Sleep Daily Routine Recreation

16. List any other major injuries you have had, other than those mentioned above: _____

17. Any other musculoskeletal problems? No Yes ...Neurological problems? No Yes

My current symptoms are increased or aggravated with the following activities:

- Walking
- Sleeping
- Standing
- Lifting
- Other _____
- Other _____

- Bending
- Lying
- Sitting

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past Present

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain

- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain

- Hip/Upper Leg Pain
- Knee/Lower Leg Pain
- Ankle/Foot Pain

Jaw Pain

- Joint Swelling/Stiffness
- Arthritis
- Rheumatoid Arthritis

- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Angina
- Kidney Stones
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems

- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder

- Cancer
- Tumor

- Asthma
- Chronic Sinusitis

Past Present

- Diabetes
- Excessive Thirst
- Frequent Urination
- Smoking/Use of Tobacco Products
- Drug/Alcohol Dependence

- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/AIDS

Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

Other Health Problems/Issues

Indicate if an immediate family member has had any of the following:

- Rheumatoid Arthritis
- Heart Problems
- Diabetes
- Cancer
- Lupus

Have you ever been under Chiropractic Care? **Y / N** If so, By whom? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? **Y / N** If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers _____ Insulin _____ Cholesterol Meds _____

Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

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

Patient/Guardian Signature _____ Date: _____