Jacoby Chiropractic LLC

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Date _____ File #: _____

CONFIDENTIAL CASE HISTORY

Name _____ Home Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Employed By _____ Address _____
Occupation _____ Work Phone _____
Date of Birth _____ Age _____ Sex: M / F Hgt. _____ Wgt. _____
Are you? _____ right handed _____ left handed _____ ambidextrous
Marital Status _____ Spouse _____ # of Children _____
Referred by _____ E-Mail Address _____

How is most of your day spent? _____ Standing _____ Sitting _____ Walking _____ Lifting/Carrying
Have you ever been to a chiropractor? _____ No _____ Yes When & Why? _____

Is this? _____ Work Related _____ Auto Related _____ N/A

Current Complaints or Issues that Brought You Here:

Describe each complaint or issue. When did it begin? How long have you had it?

Have you had MRI, CT scan, Xrays? ____ No ____ Yes When/Where? _____
Is your condition: _____ Improving _____ Getting Worse _____ The Same Does pain wake you from deep sleep? _____
Are symptoms interfering with: _____ Work _____ Sleep _____ Activities/Sports _____ Home Life
Have you seen any other healthcare providers (MD's, PT's etc.) for this condition? _____ No _____ Yes
Please describe: _____

Describe Each Problem or Painful Body Region Separately (as best you can, e.g. "headaches, or lower back").

Problem Area #1: _____
How often are your symptoms present? (Occasional) _____ 0-25% _____ 26-50% _____ 51-75% _____ 76-100% (Constant)
Grade your pain from 0 (no pain) to 10 (unbearable) 0 1 2 3 4 5 6 7 8 9 10
What provokes or alleviates your symptoms? _____

Problem Area #2: _____

How often are your symptoms present? (Occasional) _____ 0-25% _____ 26-50% _____ 51-75% _____ 76-100% (Constant)

Grade your pain from 0 (no pain) to 10 (unbearable) 0 1 2 3 4 5 6 7 8 9 10

What provokes or alleviates your symptoms? _____

Problem Area #3: _____

How often are your symptoms present? (Occasional) _____ 0-25% _____ 26-50% _____ 51-75% _____ 76-100% (Constant)

Grade your pain from 0 (no pain) to 10 (unbearable) 0 1 2 3 4 5 6 7 8 9 10

What provokes or alleviates your symptoms? _____

Past Medical History:

If you've ever in the past been medically treated for, been diagnosed with, or had significant medical problems with any of the following conditions:

___ Back Pain	___ Concussion	___ Irritable	___ HIV +	___ Nervousness
___ Neck Pain	___ Struck Unconscious	___ Digestion Problems	___ Hepatitis	___ Depression
___ Numbness/Tingling	___ Eye Injuries	___ Heart Problem	___ Mononucleosis	___ Anxiety
___ Sciatica	___ Sinus Problems	___ Kidney Problem	___ Anemia	___ Chemical Addiction
___ Jaw Pain/TMJ	___ Shortness of Breath	___ Thyroid Problem	___ Excessive Thirst	___ Eating Disorder
___ Headaches	___ Dizziness	___ Liver Problem	___ Night Sweats	___ Allergies
___ Shoulder	___ Chest Pains	___ Gall Bladder Problem	___ Weight Loss	___ Difficulty Breathing
___ Elbow/Arm	___ High Blood Pressure	___ Lung Disease	___ Frequent Urination	___ Asthma
___ Carpal Tunnel Syn.	___ Arteriosclerosis	___ Menstrual Irregularity	___ Diabetes	___ Chronic Cough
___ Knee Problems	___ Constipation	___ Menstrual Cramps	___ Limb Edema	___ Cancer
___ Foot or Ankle	___ Sleep Disorder	___ Prostate Problem	___ Bruise Easily	___ Lumps or Tumors
___ Tendonitis/Bursitis	___ Fractures	___ Uterus/Ovary Prob's	___ Chronic Fatigue	___ **Other:**
___ Sprained Ankle(s)	___ Osteoporosis ("penia)	___ Skin Disease	___ Lymes Disease	___ **Other:**

List **all surgeries** or **major injuries** or **hospitalizations** you had in the past. Do you have any residual issues?

_____

_____

_____

_____

List **all** medicines, herbs/vitamins you currently take (attach or email a list if you prefer):

_____

_____

_____

_____

Social History:

Do you smoke? ___ No ___ Yes How much?_____

Consume Alcohol? ___ Daily ___ Weekly ___ Seldom ___ Never

Do you eat "fast" food? ___ Daily ___ Weekly ___ Seldom ___ Never

Caffeine Beverages/Day ___ 4-6/d ___ 2-3/d ___1-2/d ___ Seldom/Never

Family Medical History: e.g. Diabetes Arthritis, Cancer…

Mother:

Father:

Siblings:

Do you have a regular exercise program? ___ No ___ Yes If yes, what and how often?

_____

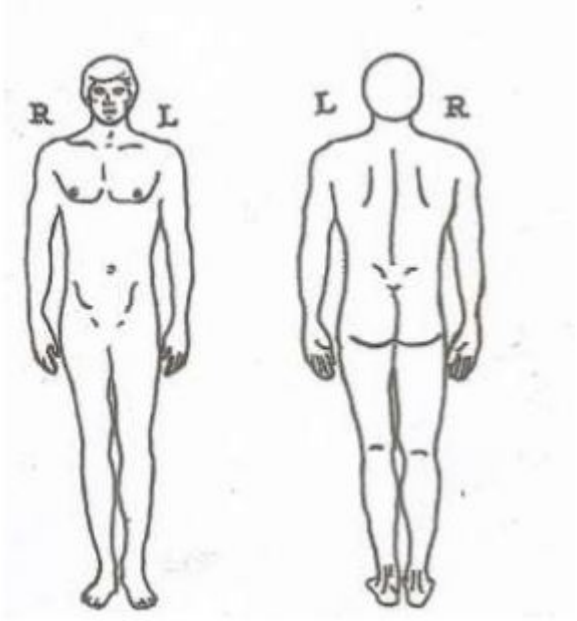
List any hobbies or sports you participate in:

_____

Were you very active in any particular sports when you were younger (e.g. high school track, college football)?

_____

Please mark your problem areas on the figures below. Please use the symbols in the box below to describe the type(s) of pain or sensations you experience.



>>>	**Aching Pain**
XXX	**Burning Pain**
===	**Numbness**
OOO	**Pins & Needles**
////	**Stabbing Pain**

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment: _____

Do you have health insurance: Yes ___ No ___

Company _____

Are you covered by **Medicare**? Yes ___ No ___ Is **Medicare** your primary coverage? Yes ___ No ___

Signature: _____
(Guardian if patient is a minor)

Patient Signature: _____ **Date:** _____