BIG IDEA FAMILY CHIROPRACTIC
3450 Acworth Due West Rd., NW ▪ Suite 330 ▪ Kennesaw, GA 30144
678-574-5227 ▪ fax 678-574-5223

PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____

Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Gender: Male_____ Female_____

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

□ Other: _____

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List Type of Medications you are taking:

☐ Anxiety ☐ Muscle Relaxors ☐ Pain Killers ☐ Insulin ☐ Birth control ☐ Cardiovascular ☐ Allergy

☐ Seizure ☐ 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 ☐Yes

Describe:_____

_____

Date of last physical examination: _____ Do you smoke? ☐ No ☐Yes

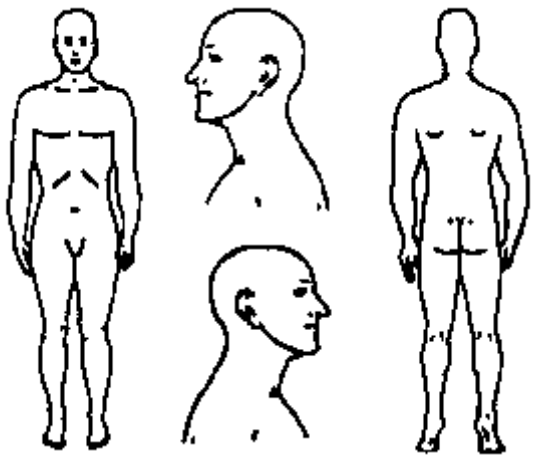
Do you drink alcohol? ☐ No ☐Yes - how many per day? _____

Do you drink caffeine? ☐ No ☐Yes - how many per day? _____

Do you exercise? ☐ No ☐Yes (what forms and how often):

_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

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

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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)?

_____

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?

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□ 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 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

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

_____

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

_____

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

_____

Have you ever had chiropractic care? ____ No ____Yes

When? _____Why? _____

Where? _____

Were X-rays taken? _____No ____Yes

When was your last adjustment? _____

Is there anything else you would like the Dr. to know about your health in order to help you? Explain

_____

_____

_____

Name: _____ Signature: _____

Date: _____