LYNCH CHIROPRACTIC CENTER
PATIENT CASE HISTORY

Name: ____ Preferred Name (Nick Name):____________________________

Address: ____________________________Apt#:________ City: ______________________ State: _______ Zip:__________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Domestic Partner ☐ Widowed

Home Phone: ______-______-________ Work: ______-______-___________ Cell Phone: _______-_______-___________

Email Address: ___________________________________ Occupation: __________________ Employer______________

Date of Birth: ________________________ Social Security #: _______-______-_______ Gender: ☐Male ☐Female

Were You Referred To Our Office? ____ NO ____YES If Yes, Please List Name(s):______________________________

Primary Care Doctor's Name:_____________________________________ Other Doctors:____________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other_____________________

Race/Ethnicity: ☐ Caucasian/White ☐Hispanic/Latino ☐Asian ☐African American ☐Other_________________

Are you covered by Health Insurance? ☐ NO ☐ YES If so, by what carrier? _____________________________________

If any sections below are left blank, "NONE" will be the default answer.

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐None ☐ Other: _______________________

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐None ☐ Other: __________

List **All Past Medical History** conditions for **YOURSELF** (not family members):

☐ 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: ____

List Type of **Medications** you are taking: ☐NONE

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

PLEASE LIST THE **NAME** OF ALL MEDICATIONS & THE **CONDITION THEY TREAT**:_____________________

____

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 ☐ Please list all family members who had/has any of the problems above:

Example(s): Paternal Grandmother - High Blood Pressure, Maternal Grandfather - Diabetes, Mother - Headaches

____

____

____

Have you had chiropractic care in the past? □ NO □YES Chiropractor's Name:_________________________________

For what condition(s) were you treated:____

Where X-rays taken? □NO □YES Approximately how long ago was your last adjustment?_______________________

Have you had any auto or other accidents? □ No □Yes If Yes - how long ago? ______________________________

Describe: ____

SOCIAL HISTORY:

Date of last physical examination: _________________

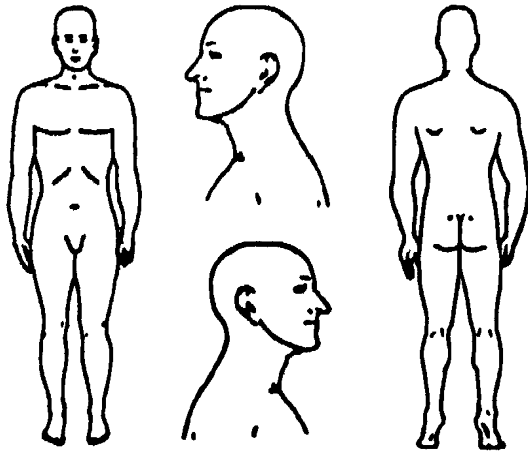
Do you smoke? □ No □ Yes If NO-Have you EVER been a smoker? □ No □ Yes If YES-How many per day? ______

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 form(s)__________________________________ How many days per week:_______

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Are you pregnant? □ No □Yes
If Yes, how many weeks? __________
Anticipated due date? _____________

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

PATIENT COMPLAINTS – PLEASE LIST ONE COMPLAINT PER SECTION

What is your **PRIMARY** complaint? **PLEASE LIST ONE COMPLAINT PER SECTION**:_______________________

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

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?

☐ 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

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

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

What is your next 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

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

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

______________________________________ ______________________________

Patient’s/Guardian’s Signature Date