lee chiropractic clinic

sports · performance · wellness

Building Body Awareness

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not find your condition will respond satisfactorily, we will not accept your case. Thank you.

Name: _____ I prefer to be called: _____
Address: _____ City: _____ Postal Code: _____
Home phone: _____ Cell phone: _____
Email: _____
*By giving your email address you consent to receiving our newsletters and office updates.
Birthdate: _____ Age: _____ Occupation: _____
Is this visit related to a car accident or an accident at work? _____

How did you hear about our office?

___ Family/Friend/Co-worker
___ Doctor
___ Internet search
_____ Public Presentation
_____ Sign
_____ Other

Please give specifics where applicable:_____

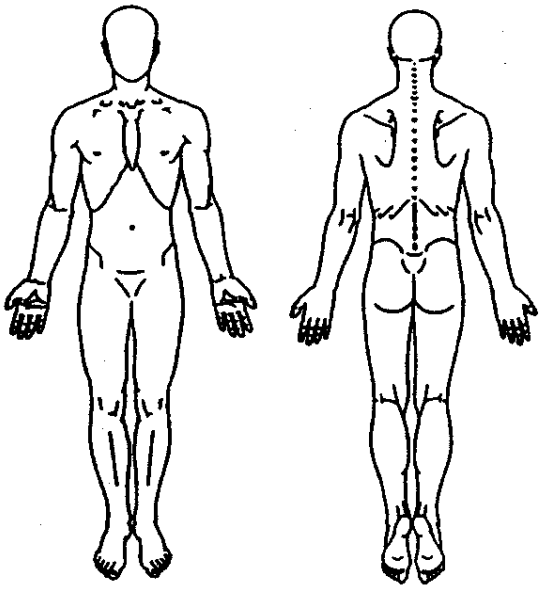
What is your major complaint?_____
Location of pain/problem: _____
Describe how it feels: _____
How long have you had this problem? _____
What, if any, activity caused this problem?_____
Have you had this or similar problems in the past? _____
What activity worsens your condition? _____
What relieves your condition? _____
Is this condition getting progressively worse?
___ Yes ___ No ___ Constant ___ Comes & Goes
Is this condition interfering with your:
___ Work ___ Sleep ___ Daily Routine ___ Other (please specify):_____
Have you had any other health care practitioners treat this condition? (eg. MD, physio, RMT, acupuncturist, osteopath) If yes, who _____

Current Pain Scale

Rate the severity of your pain by checking one box on the following scale:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Circle or shade in the areas where you feel any pain or unusual feeling on the drawing below:



Do you have any other complaints? _____
_____

Have you ever been in an auto accident?
___ Never ___ Past Year ___ Past 5 Years ___ Over 5 Years

Have you ever had a work injury?
___ Never ___ Past Year ___ Past 5 Years ___ Over 5 Years

Have you ever had any other injury?
___ Never ___ Past Year ___ Past 5 Years ___ Over 5 Years

Do you have any other health concerns? _____

Have you had any previous chiropractic care? _____

When? _____ Why? _____

Who is your family doctor? _____

Hobbies please list: _____

What are your expectations regarding your treatment? _____
_____

Have you ever had any of the following conditions?

___ Arthritis	___ Diabetes	___ Cancer
___ High Blood Pressure	___ Stroke	___ Aneurysm
___ Osteoporosis	___ Heart Conditions	___ Epilepsy

Surgical operations and year of surgery:
_____

Are you taking, or have you taken in the past, any of the following?

___ Ginkgo Biloba	___ Red Clover	___ Coumadin (warfarin)
___ Devil's Claw	___ Cranberry Extract	___ Heparin
___ Angelica Species (Don Quai)	___ Garlic Supplements	___ Other anticoagulants (specify)
___ Licorice Root	___ Aspirin (therapeutic prescription)	

Other drugs:

___ Pain Killers	___ Muscle Relaxants	___ Smoking
___ Birth Control Pills	___ Anti-inflammatories	___ Other (specify)