Kimberton Chiropractic

Adult Case History

Name____ Today's Date: ____________________

What name do you prefer to be called_____________________ Date of Birth______________ Age_______

Address___________________________________City__________________State_______Zip__________

H. Phone (____) ________________ W. Phone (____) ________________ Cell (____) ________________

May we use text to contact you: Yes No If Yes, who is your cell phone provider? __________________

May we use email to contact you: Yes No Email: ____

Social Security #______________________________ Preferred Language: ______________________

Smoking Status (Circle): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Race (Circle): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Occupation__________________________________Employer__________________________________

Marital Status S M D W Better Half's Name____

Better Half's Occupation________________________ Number of Children and Ages___________________

Do your Children have any health issues? ________ If yes, please explain ____________________________

____

Have you ever received Chiropractic Care? ________ If yes, when? For how long? ____________________

How did you hear about our office? ____

Loss of Wellness: The following three areas of stress can cause a subluxation: Physical, Emotional, Chemical.

Please circle when you experienced these stresses: C= child, T= teenager, A= adult, N= never.

I. PHYSICAL STRESS:					**EXPLAIN** (if necessary)
Slips / Falls	C	T	A	N	______________
Car Accidents	C	T	A	N	______________
Sports Injuries	C	T	A	N	______________
Work Injuries	C	T	A	N	______________
Poor Posture	C	T	A	N	______________
Sleeping Position (stomach or on a couch)	C	T	A	N	______________
Extensive Computer Work	C	T	A	N	______________
Carrying Heavy Purse/ Book bag/ Child	C	T	A	N	______________
Repetitive Lifting/ Bending	C	T	A	N	______________
Driving for many hours	C	T	A	N	______________
Continuous hours sitting/ standing	C	T	A	N	______________

II. EMOTIONAL STRESS					**EXPLAIN** (if necessary)
Stressful Relationships	C	T	A	N	______________
Hi Pressured Career	C	T	A	N	______________
Fast-Paced Life	C	T	A	N	______________
Loss of a Loved One	C	T	A	N	______________

III. CHEMICAL STRESS					**EXPLAIN** (if necessary)
Second-hand Smoke	C	T	A	N	______________
Poor Diet	C	T	A	N	______________

Alcohol C T A N ______________________________

CURRENT HEALTH HABITS	Y	N	EXPLAIN (if necessary)
Good Nutrition	_	_	______________________________
Regular Aerobic Exercise (running)	_	_	______________________________
Regular Anaerobic Exercise (strengthening)	_	_	______________________________
Proper amount of Rest	_	_	______________________________
Mental Relaxation	_	_	______________________________

SYMPTOMS (PRESENT STATE OF HEALTH)

Pain or Problem: ______________________________
Date Pain or Problem started: ______________________________
Pains are: ___ Sharp ___ Dull ___ Constant ___ Intermittent
What activities aggravate your condition/pain? ______________________________
What activities lessen your condition/pain? ______________________________
Is this condition worse during certain times of the day? ______________________________
Is this condition interfering with Work? ________ Sleep? ________ Routine? ________ Other? __________
Is this condition getting progressively worse? ______________________________
Have you seen any other doctors for this condition? ______________________________
Have you used any home remedies? ______________________________

Other Symptoms:

___ Headaches
___ Neck Pain
___ Sinus Problems
___ Blurred Vision
___ Ears Ringing/Buzzing
___ Dizzy/Lightheaded
___ Ear Infections
___ Numbness of Face
___ Thyroid Problems
___ Upper Back Pain
___ Arm/Hand Pain
___ Cold Hands
___ Heartburn/Indigestion
___ Wheezing
___ Asthma
___ Excessive Burping
___ Stomach Problems
___ Prostate Problems
___ Lower Back Pain
___ Leg Pain/Sciatica
___ Cold Feet
___ Diarrhea/Constipation
___ Colitis/Crohn's Disease
___ Weakness of the Bladder
___ Excessive Urination
___ Painful Menstruation Cycle
___ Trouble maintaining/achieving erection

Have you been under drug and medical care? ______________________________
Have you had surgery? _________ What? ______________________________ When? ____________________

Shoe Size: _________ Shoe Width: _________ Height: _________ Weight: _________

Are you currently taking any medications? Yes / No If Yes, please list medications below:

Medication Name	Dosage (# of mg)	Frequency (Times a day)

Do you have any medication allergies? Yes / No If Yes, please list medication allergies below:

Medication Name	Reaction	Onset Date	Additional Comments