



3840 E. Semoran Blvd. Ste 1054  
Apopka, FL 32703  
Ph: (407) 880-1218 Fax: (407) 749-0328

## CASE HISTORY UPDATE

Name: \_\_\_\_\_  Male  Female Age: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever received Chiropractic Care:  Yes  No If yes, when? \_\_\_\_\_

### 1. CHIEF COMPLAINT: \_\_\_\_\_

Complaint began when: \_\_\_\_\_ Duration of complaint: \_\_\_\_\_

Have you had this before: \_\_\_\_\_

Did you hurt yourself: \_\_\_\_\_

Is condition getting worse: \_\_\_\_\_ Condition interferes with: \_\_\_\_\_

How frequent is it and how long does it last: \_\_\_\_\_

Circle the Quality of the pain: dull aching sharp shooting burning throbbing deep nagging other: \_\_\_\_\_

Does any pain radiate or travel to any areas of your body: \_\_\_\_\_

Do you have any numbness or tingling in your body: \_\_\_\_\_

Grade pain Intensity/Severity: (0 = No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = Worst possible pain)

Does anything aggravate the complaint: \_\_\_\_\_

Does anything make the complaint better: \_\_\_\_\_

Previous doctors, treatments, medications, or surgery you've sought for your complaint: \_\_\_\_\_

### 2. SECONDARY COMPLAINTS: \_\_\_\_\_

### 3. PAST HEALTH HISTORY:

A. Previous illnesses you've had in your life: \_\_\_\_\_

B. Previous injury or trauma: \_\_\_\_\_

C. Allergies: \_\_\_\_\_

#### D. Medications:

Medication you are now taking

Reason for taking

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E. Surgeries: \_\_\_\_\_

Date

Type of Surgery

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**F. Females:**

Pregnancies/Date of Delivery

Outcome

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What was the date of the beginning of your last menstrual period: \_\_\_\_\_

**5. FAMILY HEALTH HISTORY:**

1. Associated health problems of relatives: \_\_\_\_\_  
\_\_\_\_\_

2. Deaths in immediate family:

Cause of parents or siblings death

Age at death

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. SOCIAL AND OCCUPATIONAL HISTORY:**

**A. Level of Education:**     high school     some college     college graduate     post graduate studies

**B. Job description:** \_\_\_\_\_

**C. Work schedule:** \_\_\_\_\_

**D. Recreational activities:** \_\_\_\_\_

**E. Level of activity:**     sedentary     moderate     active     very active

**E. Lifestyle (hobbies, alcohol, tobacco and drug use, diet):** \_\_\_\_\_  
\_\_\_\_\_

**Doctors Notes:**

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Shant Wellness to provide me with chiropractic care, in accordance with this state's statutes.*

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctors Signature: \_\_\_\_\_ Date: \_\_\_\_\_