



# Agape Sports & Family Chiropractic LLC

## Chiropractic Case History

Name \_\_\_\_\_ Sex M F Date \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

H. Phone (\_\_\_\_\_) \_\_\_\_\_ W. Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Referred by \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

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

### 1. Primary reasons for seeking chiropractic care:

Primary reason: \_\_\_\_\_

Secondary reason: \_\_\_\_\_

Other factors contributing to the primary and secondary reasons: \_\_\_\_\_

### 2. Chief Complaint: \_\_\_\_\_

Location of Complaint: \_\_\_\_\_

Complaint Began when and how? \_\_\_\_\_

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

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

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

How frequent is complaint present, how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? \_\_\_\_\_

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

### 3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 4. Past Health History:

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

\_\_\_\_\_

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

\_\_\_\_\_

Have you ever broken any bones? Which? \_\_\_\_\_

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

**D. Medications:**

Medication	Reason for taking
_____	_____
_____	_____

**E. Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____

**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____

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

**5. Family Health History:**

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

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

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

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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