

INDIALANTIC CHIROPRACTIC & ACUPUNCTURE, INC.
322 Fourth Ave, Indialantic, FL 32903
CHIROPRACTIC CASE HISTORY

Name _____ Sex M F Date _____

Address _____ City _____ State _____ Zip _____

Secondary address/phone: _____

H.Phone() _____ W.Phone _____ Cell Phone _____

Date of Birth _____ Age _____ EMAIL _____

Referred By _____ Social Security # _____ S M D W

Occupation _____ Employer _____

Emergency contact _____ Phone# _____

Are you interested in Acupuncture, Chiropractic or what the Doctor feels necessary?

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

1. Primary reasons for seeking chiropractic/acupuncture care:

Have you had an X-ray, MRI, NCS, EMG, Blood test to help diagnose this condition? If yes, Where?

2. Other complaints: _____

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)

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

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous treatments, medications, surgery, or care you've sought for your complaint: _____

Have you had any colon, heart, lung, urinary changes? If so, what? _____

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
_____	_____
_____	_____

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. Job description: _____

B. Recreational activities: _____

C. Type of Insurance: (Ex: Aetna, BCBS): _____

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/acupuncture care, in accordance with this state's statutes.

Patient or Guardian Signature: _____ Date: _____