

# Whole Health Chiropractic Center

## Case History

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

### Symptoms

Primary Complaint \_\_\_\_\_ Problem Started On \_\_\_\_\_

Pains are: Sharp Dull Throbbing Aching Numbness Shooting  
Burning Tingling Cramps Stiffness Swelling Other \_\_\_\_\_

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is this condition getting progressively worse? Yes No Unknown

Is the pain constant or does it come and go? \_\_\_\_\_ How often do you have it? \_\_\_\_\_

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are difficult to perform:

Sitting Standing Walking Bending Lying Down Other \_\_\_\_\_

What activities lessen your condition/ pain? \_\_\_\_\_

What treatment have you already received for this condition? Medications Physical Therapy  
Surgery Chiropractic None Other \_\_\_\_\_

Names of Doctors who treated you for this condition \_\_\_\_\_

Rate the priority level of your desire to correct this problem.(1,low-10,high) 1 2 3 4 5 6 7 8 9 10

Type of accident: Auto Work Home Other \_\_\_\_\_ Have you reported it? Yes No

### OTHER SYMPTOMS:

Headaches	Pins & Needles in Legs	Loss of Smell
Neck Pain	Pins & Needles in Arms	Loss of Taste
Upper Back Pain	Numbness in Fingers	Diarrhea / Constipation
Mid Back Pain	Numbness in Toes	Cold Feet
Low Back Pain	Shortness of Breath	Cold Hands
Hip Pain	Fatigue	Stomach Upset
Leg Pain	Depression	Loss of Balance
Shoulder Pain	Ears Ringing / Buzzing	Loss of Memory
Chest Pain	Light Bothers Eyes	Irritability
Dizziness/ Fainting	Nervousness	Tension

(Women) Are you Pregnant? Yes No Nursing? Yes No Taking Birth Control? Yes No

### Daily Habits

Exercise: None Moderate Daily Heavy

Work Habits: Sitting Standing Light labor Heavy labor

Sleep Position: Side Stomach Back

Do You Smoke? Yes No Packs/ Day \_\_\_\_\_

Do You Drink Alcohol? Yes No Drinks/ Week \_\_\_\_\_

Coffee/ Caffeine Drinks? Yes No Cups/ Day \_\_\_\_\_

Do You Have High Stress? Yes No Reason \_\_\_\_\_

What Vitamins/Nutritional Supplements do you take? \_\_\_\_\_

What Medications are you taking? \_\_\_\_\_