ChiropracTED, LLC
871 Coronado Center Drive, Suite 200
Henderson, NV 89052

CASE HISTORY

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 Teddy Sim, DC to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature: _____ Date: _____

Doctors Signature: _____ Date: _____