

Iowa Chiropractic Clinic, P.C.

Case History

Please complete the questionnaire. Your answers will help determine how we can help you best. (Please Print)

Date : ____/____/____

Name: _____ MI _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Patient SS# _____ - _____ - _____

Male _____ Female _____ Martial Status: S M W

Birth Date: ____/____/____

Occupation: _____

Employer: _____

Work Phone: _____

Insured's Name: _____

Insured's Address: _____

Insured's Birth Date: ____/____/____

Insured's Employer: _____

Insured's Work Phone: _____

Referred by: _____

Physician: _____

Address: _____

May we contact your physician? Yes _____ No _____

Describe present complaints and symptoms: _____

Current Medications: _____

How would you describe the pain (Circle one below)?

Constant Intermittent Local Radiating

Rate the intensity of pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

What makes the pain better?

What make the pain worse?

Date you first noticed symptoms

____/____/____

Is this condition due to an accident? Yes _____ No _____

If so, what type? Auto Work Home Other

Has this happened before? Yes _____ No _____

If so, when? _____

Pain Diagram:

____ Sharp ^^

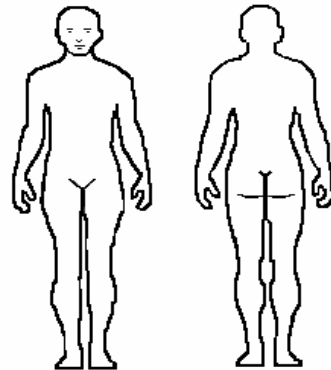
____ Dull = = =

____ Stabbing ///

____ Burning xxx

____ Tingling ooo

____ Other +++



Have you ever:

Been knocked unconscious? Yes _____ No _____

Used a crutch or other support? Yes _____ No _____

Been treated for spine/nerve disease? Yes _____ No _____

Had a fractured bone? Yes _____ No _____

Had surgery? Yes _____ No _____

Had any other hospitalizations? Yes _____ No _____

Had any mental/emotional disorders? Yes _____ No _____

Been in an auto accident? (Circle 1 below if applicable)

Never Past year Past 5 years Over 5 years

Had a personal injury? (Circle one below if applicable)

Never Past year Past 5 years Over 5 years