SiMPly Chiropractic - Dr. Steven M. Poulos D.C.

Case History of Complaint

Name____Sex M F Date______________________________________

Address____State________________Zip__________________

H. Phone(________)__________________W. Phone___________________ Date of Birth_________________ Age__________

Referred by____ History of stroke or high blood pressure ☐ Yes ☐ No

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

1. **Primary reasons for seeking chiropractic care:**
   ☐ Relief care ☐ Correction of cause care ☐ Wellness care

2. **Chief Complaint:** ____

Location of Complaint: ____

Complaint Began when and how? ____
Was the complaint the result of an accident or injury in a vehicle? ☐ Yes ☐ No
Was the complaint the result of an accident or injury at work? ☐ Yes ☐ No

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/ Review of Systems:**

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. <u>Family Health History:</u>

Associated health problems of relatives: ______________________________

____

Deaths in immediate family:

Cause of parents or siblings death | Age at death

______________________________ ______________

______________________________ ______________

______________________________ ______________

6. <u>Social and Occupational History:</u>

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job description: ______________________________

C. Work schedule: ______________________________

D. Recreational activities: ______________________________

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

1. Hobbies:______________________________
2. How often to you exercise? ☐ None ☐ 1-3 times per week ☐ 4-5 times per week ☐ Daily
3. Do you use alcohol? ☐ Yes ☐ No If yes, How often?_________drinks per ___________
4. Do you use tobacco products ☐ Yes ☐ No If yes, how often _________cigs/chew per _________
5. Do you use illegal drugs or prescriptions that are not prescribed to you? ☐ Yes ☐ No

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 ______________