

Dr. Matt's Wellness Center
4031 W. Plano Pkwy Suite 201
Plano, TX 75093
(972) 867-9900

Chiropractic Case History

Name: _____ Sex: M F Date: _____

Address: _____ City: _____

State: _____ ZIP: _____ Marital Status: Married Single

H.Phone (_____) _____ W.Phone (_____) _____ C.Phone (_____) _____

Date of Birth: _____ Age: _____ Social Security # _____

Referred by: _____ Occupation: _____

Employer: _____ Email: _____

1. Primary reasons for seeking Chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

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 complaint/pain 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:

A. Previous illness you have 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. 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. Level of Education:

High School Some College College Graduate Post Graduate Studies

B. Job Description: _____

C. Work Schedule: _____

D. Recreational Activities: _____

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

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.

Signature _____

Date _____

Doctor's Signature _____

Date _____