# COUNTRY ROADS

Mobile Chiropractic

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## Case History Form

### General Information

Name: _____ Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip:_____

Primary Phone: _____ Secondary Phone: _____

Sex: Male Female Marital Status: S / M / D / W Spouses name: _____

Weight: _____ Height: _____ Email Address: _____

Occupation: _____ Employer: _____

Do you have any Children: _____

Have you received chiropractic care previously? Yes __ No __ When_____

How did you hear about us? _____

### Emergency Contact

Name: _____ Relation: _____ Phone: _____

### Goals

What do you hope to achieve by being under care?

___ Decreased Pain
___ Maintain my health
___ Improve my health
___ Stress Management
___ Improve my body's function

What is your goal for your health care?

_____

_____

**Complaint Information**

What brings you to our office?

_____

_____

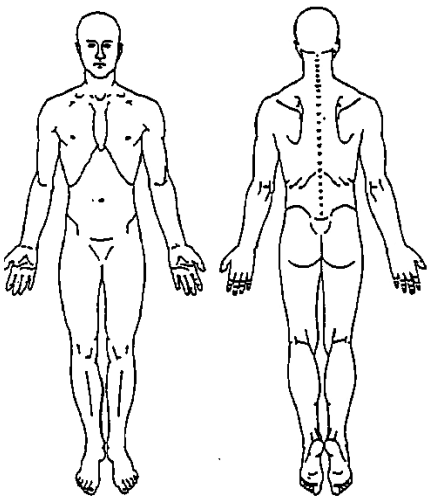
When did this start? _____ Have you had this issue before? _____

Have you seen other providers? Yes __ No __Is this condition getting progressively worse? Yes __No __

What other treatments have you tried?

_____

_____



On the image to the left, please mark your areas of concern.
Please circle the degree of pain, 0 = none, 10 = severe
0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain?
- Numb
- Dull
- Achy
- Sharp/Stabbing
- Burning
- Pins/Needles
- Electric
- Other: _____

What activities make your condition worse? _____

Does anything help make your condition better? _____

Does your pain radiate anywhere? _____
Does your condition interfere with any of the following? Please mark Y or N and describe on the line for any you marked yes.

____ Work _____

____ Sleep _____

____ Daily Routine _____

____ Hobbies _____

____Other _____

**Health History**

Are you taking any Medications/Supplements? _____

_____

Any previous surgeries? _____

Previous injuries/car accidents? _____

Do you smoke cigarettes? Yes No, If yes, how often _____ Caffeinated drinks per day? _____

Do you drink alcohol? Yes No, If yes, how often _____

Recreational Drug use? Yes No, If yes, what is it _____ How often _____

Do you exercise? _____

Do you follow any specific diets? _____

Do you or a relative have any of the following conditions?

| **Condition** | **I have this** | **My _____ has this** | **Specify type if applicable** |
|---|---|---|---|
| Cancer | | | |
| Diabetes | | | |
| Sleep Disorders | | | |
| Asthma | | | |
| Emphysema | | | |
| Chronic Bronchitis | | | |
| Seizures | | | |
| Mental Health Disorders | | | |
| Lyme Disease | | | |
| Vertigo | | | |
| Blindness | | | |
| Infertility | | | |
| Hypertension | | | |
| COPD | | | |
| Osteoporosis | | | |
| Liver disease | | | |
| Heart Disease | | | |
| Thyroid Dysfunction | | | |
| Ankylosing Spondylitis | | | |
| Herniated Disc | | | |
| Anemia | | | |
| Other | | | |
| Other | | | |

By signing my name below I acknowledge that I have filled this form out to the best of my ability and as accurately as possible.

Signature: _____ Date: _____