Right Health Clinic
716 W Brookside St
Colorado Springs, CO 80905 719-475-9103

CASE HISTORY

Name: _____ 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: _____

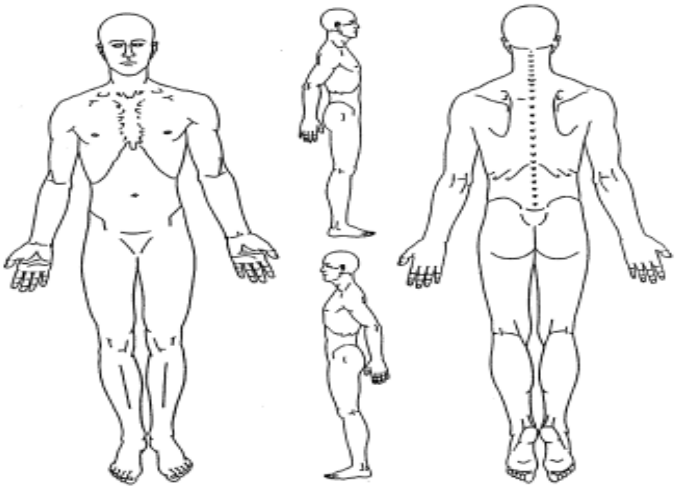
Previous doctors, treatments, medications, or surgery you've sought for your complaint: _____

_____

2. SECONDARY COMPLAINTS: _____

_____

Circle or otherwise indicate areas of complaints.



Name: _____ Date: _____

3. PAST HEALTH HISTORY:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma: _____

_____

C. Allergies: _____

D. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

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. Job description: _____

B. Work schedule: _____

C. Level of activity: ☐ sedentary ☐ moderate ☐ active ☐ very active

D. Lifestyle (hobbies, recreational activities, alcohol, tobacco and drug use, diet, water intake):

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Right Health Clinic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature: _____ Date: _____

Doctors Signature: _____ Date: _____