Silcox– Acupuncture & Chiropractic

728 Stone St., Ste E. Fremont, OH 43420 419-307-8094

Case History

Name_____Sex M F Date_____

Address_____ City _____State_____Zip _____

Referred by_____ Email _____

H. Phone(_____)_____C. Phone (_____)_____ Date of Birth_____ Age_____

Occupation_____ Employer_____

Previous Chiropractic Care? Yes No Acupuncture? Yes No Nutrition? Yes No

Chief Complaint: ________

Complaint began when and how? _____

Please circle the Quality of the 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? _____

Previous treatments you've sought for your complaint: _____

_____

Have any x-rays been taken? [ ] No [ ] Yes Where? _____

Previous illnesses you've had in your life: _____

_____

Previous injury or trauma:_____

_____

Have you ever broken any bones? No If Yes, Which? _____

Medications:

Medication	Reason for taking
_____	_____
_____	_____

Allergies _____

OVER

Surgeries:

Year	Type of Surgery
_____	_____
_____	_____
_____	_____

Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

Social and Occupational History:

Level of Education:

[ ] High School [ ] Some College [ ] College Graduate [ ] Post Graduate Studies

Job description: _____

Work schedule: _____

Recreational activities: _____

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 to provide me with health care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____