Hatfield Chiropractic Clinic
130 North Main Street, Marysville OH 43040
(937) 644-4310 (p) ~ (937) 644-3228 (f)

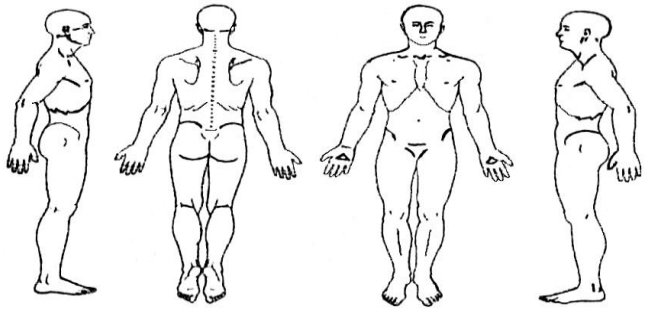
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition ____ Improved ____ Gotten Worse ____ Stayed the same since it began?
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
13. Have you been treated for this before? ____No ____Yes How long ago? _____
14. What treatment did you receive? _____
15. Results of previous treatment? ____Good ____Poor Comments _____
16. List any other major injuries you have had, other than those mentioned above: _____

_____

17. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes
18. Are your present symptoms related to an auto accident, work-related injury, or other personal injury? ____ Yes ____ No
19. Women: Any chance you may be pregnant? _____ Yes _____ N

(Continue on back)

Patient Name: _____

Medical History

Family Physician: _____ (Note: May we send your health information to this provider **Y / N**)

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

Please list any medications or drugs are you taking? _____

_____

Please check any conditions current or past experienced by you or your immediate family (list your relation):

	You	Family		You	Family
Arthritis	____	_____	High Blood Pressure	____	_____
Asthma	____	_____	Insomnia	____	_____
Allergies	____	_____	Kidney Problems	____	_____
Bursitis	____	_____	Liver Problems	____	_____
Cancer	____	_____	Migraines	____	_____
Cardiovascular	____	_____	Nervousness/Anxiety	____	_____
Constipation	____	_____	Neuritis	____	_____
Diabetes	____	_____	Neuralgia	____	_____
Disc Problems	____	_____	Pinched Nerve	____	_____
Emphysema	____	_____	Scoliosis	____	_____
Epilepsy	____	_____	Sinus Problems	____	_____
Fatigue	____	_____	Stomach	____	_____
Headaches	____	_____	Stress	____	_____
Other _____	____	_____	Other_____	____	_____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____