

Brooksville Chiropractic Inc.
813 S. Broad St.
Brooksville, Fl. 34601
(352)799-3433

Patient DOB: _____
Patient MR#: _____

CASE HISTORY

Full Name: _____ Date: _____

History of Present Injury/Illness

Please list below complaint(s) you have in order of importance. Also the length of time you have had these complaint(s).

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

Is your condition(s) related to an accident: YES NO

Date of accident: _____ Type of accident: Auto Work Related Other _____

Have you had any previous Trauma or Accidents? When _____

When is your condition most severe? _____

When is your condition least severe? _____

What makes your condition feel worse? _____

What makes your condition feel better? _____

Have you seen any other health care provider for you present condition? YES NO

Who? _____

Current Medications _____ () None

Allergies _____ () None

Are you or could you be pregnant? YES NO 1st day of last menstrual period _____

Do you use Alcohol Tobacco Other Substances: _____ () None

Are you experiencing or do you have any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> A sore that won't heal | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Persistent cough/hoarseness |
| <input type="checkbox"/> Any bleeding/discharge | <input type="checkbox"/> Lump/thickening anywhere | <input type="checkbox"/> Wart/mole changes |
| <input type="checkbox"/> Bladder/bowel problems | <input type="checkbox"/> Night pain | <input type="checkbox"/> Weight loss without trying |
| | | <input type="checkbox"/> None of the above |

Review of Systems

In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Facial drooping | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Atrophy | <input type="checkbox"/> Headache | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Sensory changes |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Joint deformity | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Joint locking | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Numbness | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Popping noises | <input type="checkbox"/> Twitches |
| <input type="checkbox"/> Vision trouble | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Extremity deformity | <input type="checkbox"/> Psychiatric disorders |
| | | | <input type="checkbox"/> None of the above |

Cardiovascular System

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Known vascular disease | <input type="checkbox"/> Previous stroke |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Carotid blockage | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Changes in skin color | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Varicose veins |
| | | | <input type="checkbox"/> None of the above |

Past History

List any surgeries you have had (including appendix, tonsils, and wisdom teeth)

1. _____ Date _____ 3. _____ Date _____
2. _____ Date _____ 4. _____ Date _____

Have you ever been hospitalized in addition to surgeries? YES NO

If so, when and for what reason? _____

Have you ever been diagnosed with any condition? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)

YES NO _____

Do you have a family history of any disease? (diabetes, heart trouble, cancer, stroke, rheumatoid, etc.)

Yes NO _____

Are you currently under a doctor's care for conditions other than ones you are seeking care for today?

YES NO _____