Crossroads Chiropractic
2826 Moody Parkway Ste A
Moody, Al 35004
(205) 640-6500

Confidential Case History

Please Print Dr. Mr. Mrs. Ms. Miss Referred By:_____

Date:_____ Cell#_____

Name:_____ Home#_____ Work#_____

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

SS#:_____ Date of Birth:_____ Age:_____ Sex: M F

Occupation:_____ Employer:_____ Yrs. Employed:_____

If retired, former occupation:_____ Education level obtained:_____

Marital Status:___ Spouse's Name:_____ Spouse's Occupation:_____
Primary Care Physician (name, address and
telephone:_____

NOTE: If you're on Medicare, please show your card to the receptionist.

PLEASE RANK ONLY 3 MAIN PAIN COMPLAINTS

1)._____

2.)_____

3)._____

Briefly describe HOW, WHEN, and WHERE you began having your pain complaint

_____
_____
_____
_____
_____

Accident or Injury date if applicable:_____
Injury occurred:_____ At work or work related
_____ At home
_____ In a car accident
_____ Unknown cause (happened spontaneously)
_____ Other _____

Modality	Last Time Used or Performed	Result
Rest at Home		
Home Exercise Program		
TENS Unit		
Chiropractic Care		
Acupuncture		
Physical Therapy		
Occupational Therapy		
Work Hardening		
Epidural Nerve Blocks/Duramorphs		
Other		
CURRENT MEDICATIONS (name, strength, how many per day)		

_____
_____
_____
_____
_____
_____

Your Past Medical History (Please check or list all OTHER medical conditions)

_____ Heart Disease
_____ Lung Disease
_____ Kidney Disease
_____ Diabetes
_____ High Blood Pressure
_____ Peptic Ulcer Disease or severe Heart Burn
_____ Arthritis
_____ Fractures (Broken Bones)
_____ Other_____

Your Past Surgical History (Please list all operations and procedures you have ever had)

DATE OPERATION SURGEON

_____
_____
_____
_____
_____
_____
_____

WHEN IS YOUR PAIN BETTER?
___Lying down ___Medication ___Range of Motion ___Standing ___Stretching ___Heat
___Ice ___Sitting ___Nothing ___Resting ___Chiropractic treatment ___Laying on left side
___Laying on right side ___Leaning to left ___Leaning to right

WHEN IS YOUR PAIN WORSE?
___Lying down ___Movement ___Prolonged Sitting ___Prolonged Standing
___Prolonged Walking ___Sneezing ___Daily Living Activities ___Rotation Left
___Rotation Right ___Laying to Standing ___Laying to Sitting ___Sitting to Laying
___Sitting to Standing ___Standing to Laying ___Standing to Sitting ___Bright lights
___Driving ___Lifting

WHAT IS THE QUALITY OF YOUR PAIN?
___Aching ___Electric ___Dull ___Fiery ___Sharp ___Shooting ___Stabbing ___Deep
___Throbbing ___Superficial

DOES THE PAIN RADIATE TO ANY PART OF YOUR BODY?_____ IF YES, WHERE?_____

WHAT IS THE TIMING OF YOUR PAIN?
___Afternoon ___Evening ___During night ___Light Activity ___Moderate Activity
___Morning

WHAT ARE THE SIDE EFFECTS OF YOUR PAIN?
___Decreased Range of Motion ___Increased Sensitivity ___Numbness ___Stiffness
___Tingling ___Tightness

PRESENT FUNCTION
How long are you able to walk?_____minutes/hours
What prevents you from walking longer?_____
How long can you comfortably sit?_____
I am able to perform household duties/chores:
Almost Always / Most of the time / Occasionally / Rarely
I sleep about _____ hours a night. My sleep is: Good / Fair / Poor
If you have trouble sleeping, what interferes with your sleep?_____
List your usual activities/hobbies/chores that you enjoy and indicate if you have been able to do them since you condition has occurred:

_____

Tests Performed	Performed	Ordered by	Test Results	Recommended
Example: MRI, X-Rays,	when and where?	what Physician?	Revealed what	Treatment
Labs, Myelograms Etc.			findings?	

FAMILY HISTORY

Mother: Living / Deceased Medical Problems_____
Father: Living / Deceased Medical Problems_____
How many Brothers_____ Sisters_____ Medical Problems_____

Do You Now Have or Ever Have Had Problems With Any of the Following Areas?

___ENT ___EYES ___Heart or Vessels ___Abdomen ___Genitourinary
___SKIN ___Hormones ___Muscles ___Large Weight Swings ___Hepatitis
___HIV (Aids Virus) ___Psycologic or Psychiatric Treatment
Other:_____

HAVE YOU BEEN DIAGNOSED OR BEEN TOLD YOU HAVE THE FOLLOWING:

Y N High blood pressure
Y N Hardening of the arteries
Y N Diabetes
Y N Heart or blood vessel disease
Y N Bone spurs on the neck
Y N Whiplash injury
Y N Any relatives ever suffer a stroke
Y N Blurred Vision
Y N Do you currently smoke?
Y N Have you smoked in the past?

MEN ONLY:

Date of last prostate exam:_____
Difficulty with urination?_____
Excessive urination?_____

WOMEN ONLY:

Do you experience any of the following symptoms?

Y N Do you take birth control pill?
How long?____
Y N Menstrual pain
Y N Cramping
Y N Irregularity
Date of last period_____
Y N Are you pregnant?_____ How long?_____

HAVE YOU HAD ANY OF THESE FOLLOWING SYMPTOMS FOR EVEN A SHORT OR TEMPORARY DURATION WITHIN THE LAST YEAR?

Y N Slurred speech or other speech problems
Y N Difficulty swallowing
Y N Dizziness
Y N Temporary lack of understanding
Y N Loss of consciousness, even momentary blackouts
Y N Numbness or loss of sensation in the face, arms, hands, fingers or legs
Y N Any other abnormal or loss of sensation in any other part of the body
Y N Weakness, clumsiness, or strength loss in the face, arms, hands, fingers or legs
Y N Sudden collapse without loss of consciousness
Y N Diminished or partial loss of vision in one or both eyes
Y N Hearing loss in one or both ears

ATTENTION - Payments are to be made at the time of the visit unless prior arrangements have been made with this office. Also a 24-hour notice is necessary to cancel an appointment, and you may be responsible for payment of a missed appointment.

I hereby consent to any procedure or treatment necessary for treatment of any condition as deemed reasonable by the attending doctor.

Patient Signature_____ Date_____