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 _____

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
CURRENT MEDICATIONS (name, strength, how many per day)

_____
_____
_____
_____
_____
_____

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

Tests Performed Ex: MRI, X-Rays, Labs, Myelograms Etc. (when and where)
_____
_____
_____

Personal, Family and Social History

My current condition(s) interfere with: ☐ Work ☐ Recreation ☐ Household Responsibilities
☐ Relationships Explain: _____

Illnesses
Had / Have

☐ ☐ Aids
☐ ☐ Alcoholism
☐ ☐ Allergies
☐ ☐ Arteriosclerosis
☐ ☐ Cancer
☐ ☐ Chicken Pox
☐ ☐ Diabetes
☐ ☐ Epilepsy
☐ ☐ Glaucoma
☐ ☐ Goiter
☐ ☐ Heart Disease
☐ ☐ Hepatitis
☐ ☐ HIV Positive
☐ ☐ Malaria
☐ ☐ Measles
☐ ☐ Multiple Sclerosis
☐ ☐ Mumps
☐ ☐ Polio
☐ ☐ Rheumatic Fever
☐ ☐ Scarlet Fever
☐ ☐ STD / STI
☐ ☐ Stroke
☐ ☐ Tuberculosis
☐ ☐ Typhoid
☐ ☐ Ulcer
☐ ☐ Other

Operations
Surgical Interventions which may or may not have required hospitalization

☐ Appendix
☐ Cancer
☐ Cardiac Bypass
☐ Cosmetic Surgery
☐ C-Section
☐ Eye Surgery
☐ Hysterectomy
☐ Pacemaker
☐ Tonsillectomy
☐ Vasectomy
☐ Spinal _____
_____
_____
☐ Other _____
_____

Injuries
Have you ever...

☐ Broken/fractured a bone
☐ Had a spine or nerve disorder
☐ Used a neck or back brace
☐ Been knocked unconscious
☐ Been injured in an accident
☐ Used a crutch or support

Allergies
Environmental, Pharmaceutical, Food

_____
_____
_____

Social History
Daily / Weekly / Amount

☐ ☐ _____ Alcohol
☐ ☐ _____ Caffeine
☐ ☐ _____ Tobacco
☐ ☐ _____ Exercise
☐ ☐ _____ Water
☐ ☐ _____ Prescription
☐ ☐ _____ Other

Stress and Health Information

☐ Yes ☐ No Job Pressure/Stress
☐ Yes ☐ No Recreational Drugs
☐ Yes ☐ No Vaccinated

My stress levels are:
☐ Low ☐ Medium ☐ High

Hobbies: _____
_____
_____
_____

Family History

Relative	*Age*	*Health Status Good/Poor*	*Illness*	*Age at Death*	*Cause of Death Natural/Illness*
Mother	_____	☐ ☐	_____	_____	☐ ☐
Father	_____	☐ ☐	_____	_____	☐ ☐
Sibling	_____	☐ ☐	_____	_____	☐ ☐
Sibling	_____	☐ ☐	_____	_____	☐ ☐

Patient Name: _____ Date: _____ _____
Doctor's Initials

Patient Review of Systems

The Nervous System controls and coordinates all organs and structures of the Human Body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)	
CERVICAL	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory Processing ☐☐ ADD/ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ/Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
UPPER THORACIC	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux/GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
MID THORACIC	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain/Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
LOWER THORACIC	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions/Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
LUMBAR, SACRUM & PELVIS	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic/SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance

Patient Name: _____ Date: _____ _____

Doctor's Initials

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Activities of Daily Living

How does this current condition interfere with your ability to function or complete routine activities on a dail basis?

	No Effect	*Mild*	*Moderate*	*Severe*
Sleeping	☐	☐	☐	☐
Rising out of a chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of a car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Yard work	☐	☐	☐	☐

What is the major stressor in your life? _____

How much on average do you sleep per night? _____

What is the approximate age of your mattress? _____

What is your preferred sleep position?

_____

Describe your typical eating habits...

☐ Skip breakfast
☐ Two meals per day
☐ Three meals per day
☐ Snacking between meals

What is your ideal outcome from the care that you receive here?

_____
_____
_____
_____
_____
_____
_____
_____

Acknowledgments

To help us improve communication and achieve the best results for your care, please read and initial the statements below.

_____Initial I understand the Privacy Policy and know that I may request a copy at any time.

_____ Initial I give my permission to contact me via phone, email or letter in order to communicate regarding appointments, reschedules, account information or other issues related to my care.

_____ Initial I attest that the information provided here is complete and truthful.

Patient Name: _____ Date: _____ _____

Doctor's Initials