

Best Choice Chiropractic & Wellness Center
2512 Oakland Blvd. #12
Fort Worth Texas 76103

CASE HISTORY

Name _____ Age _____ Date _____
Address _____ City _____ State _____
Zip _____
Phone (Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W
Social Security # _____ Driver's License

Occupation Employer _____
Phone (Work) _____
Insurance Company _____
Phone _____
Insured's Name _____
Insured's Date of Birth _____
Insured's ID. # or S.S. # _____
Spouse's Name _____
Spouse's Occupation _____
Spouse's Employer _____
Spouse's Phone (Work) _____
Spouse's Insurance Co. _____
Phone _____
Spouse's Social Security # _____
Present condition due to an injury? Yes No On the Job Auto Accident Other

Has the accident been reported? Yes No To Employer Auto Carrier Other

HEALTH REPORT:

Reason for seeking care: _____
List any other doctors seen for this: _____
List any diagnosis and type of treatment: _____
Have you had similar accidents or injuries before? Yes No If yes, explain: _____
List the names of any relatives that have or have had a similar problem: _____
Have you or any relative received chiropractic treatment previously? Yes No
If yes, explain: _____
Have you been treated for any health condition by a physician in the last year? Yes No
If yes, explain: _____
Are you currently taking medication? Yes No list medications: _____

Have you taken medication in the past? Yes No list medications

List conditions you are taking medications for:

List the approximate dates of any surgery or treated conditions: _____

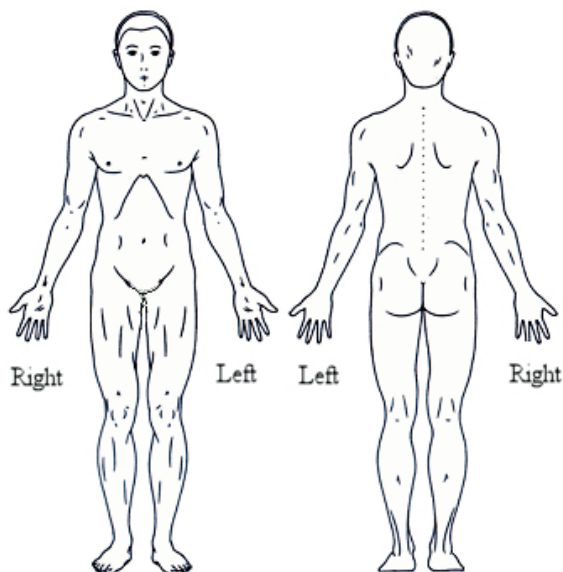
Family History: Health conditions, age of death and cause of death.
Father: _____

Mother: _____

Brother/s & Sister/s: _____

Do you smoke Y/N _____ · Alcohol Y/N ___ Daily ___ Weekly ___ Social Occasions · Caffeinated drinks per day _____

Do you take Vitamins/Supplements Y/N If yes, type and how often



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness = = =

Dull Ache O O O

Burning X X X

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with Work? _____

Sleep? _____ Routine? _____ Other? _____

Is this condition progressively getting worse? _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises

- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain

Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____