**Dr. Kendra Brough**

Towne Centre Chiropractic Clinic

Date: _____

## CONFIDENTIAL CASE HISTORY

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

## PERSONAL INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr. Name:_____

How do you wish to be addressed in our office? ❑ First Name ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr.

Marital Status: ❑ M ❑ S ❑ W ❑ D

Address: _____City: _____

Postal Code: _____ Home Phone: _____Business Phone: _____

Date of Birth: dd_____mm_____yr_____ e-mail address: _____

Employer:_____ Address: _____

Occupation: _____ Hobbies: (What occupies your spare time?) _____

Spouse's or Partner's Name: _____

Employer:_____Telephone:_____

How did you hear about our office? _____

Medical Doctor's Name: _____

Would you like a medical report forwarded to your MD? ❑ Yes ❑ No

I consent to the clinic to communicate electronically with me for the purpose of scheduling appointments, appointment confirmations, clinic updates and newsletters. ❑ Yes ❑ No

## HEALTH INFORMATION

Have you ever been to a chiropractor before? ❑ No ❑ Yes, Doctor's Name:_____

When was your last visit? _____ What was the problem? _____

Have you had previous healthcare for this problem? ❑ Yes ❑ No

Where? _____ When? _____

Were x-rays taken? _____

## REASON FOR CONSULTING OUR OFFICE

What is your major complaint? _____

Is this complaint a result of a motor vehicle accident? ❑ No ❑ Yes

Is this a Workman's Compensation case? ❑ No ❑ Yes

How long have you had this condition?_____

_____

Have you had this or similar conditions in the past? ❑ No ❑ Yes, and when? _____

_____

What activities aggravate your condition? _____

What makes it better? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes_____

Is this condition interfering with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other _____

*(Please complete both sides)*

How long has it been since you really felt well? _____

Has there been any medical diagnosis of your complaint? ❑ No ❑ Yes, if yes list the Dr.'s name and diagnosis:

_____

List surgical operations and years: _____

_____

List any Prescription Drugs, Over the counter Drugs, Vitamins and Natural Supplements you are currently taking: _____

_____

Age of Mattress: _____ Comfortable: ❑ Yes ❑ No

Do you wear: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner soles ❑ Arch supports ❑ Orthotics

Have you been in an auto accident: ❑ Never ❑ Past year ❑ Past 5 years ❑ Over 5 years

Description of accident: _____

_____

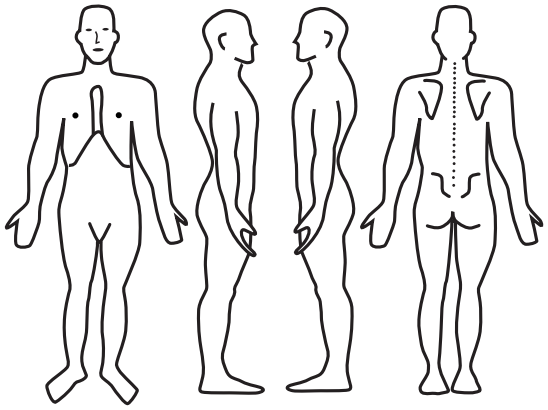
Have you had any other personal injury or accident: ❑ None ❑ Past year ❑ Past 5 years ❑ Over 5 years

Description of accident: _____

_____

Date of most recent physical examination: _____

**Please mark the areas of pain and/or discomfort on the figures below:**



Front Right Left Back

**Please rate your current level of discomfort:**

| | No Pain | | | | | Moderate Pain | | | | Unbearable Pain |
|---|---|---|---|---|---|---|---|---|---|---|
| **Neck:** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Mid Back:** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Low Back:** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

**Are you affected by any of the following?** Please check ❑ O = Occasionally F = Frequently C = Constantly

| | O | F | C | | O | F | C | | O | F | C |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Asthma | ❑ | ❑ | ❑ | Headaches | ❑ | ❑ | ❑ | Dizziness | ❑ | ❑ | ❑ |
| Low Back pain | ❑ | ❑ | ❑ | Sinus Trouble | ❑ | ❑ | ❑ | High blood pressure | ❑ | ❑ | ❑ |
| Neck pain | ❑ | ❑ | ❑ | Digestive Upset | ❑ | ❑ | ❑ | Females Only: | | | |
| Allergies | ❑ | ❑ | ❑ | Constipation | ❑ | ❑ | ❑ | Painful menstruation | ❑ | ❑ | ❑ |
| Earache | ❑ | ❑ | ❑ | Heartburn | ❑ | ❑ | ❑ | PMS | ❑ | ❑ | ❑ |
| Sore Throat | ❑ | ❑ | ❑ | Migraines | ❑ | ❑ | ❑ | Are you pregnant? Yes ❑ | | | No ❑ |

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ Dated: _____

Patient consent for examination _____
Doctor's Initials