

**Dr. Kendra Brough**

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**CONFIDENTIAL CASE HISTORY**

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Date: \_\_\_\_\_

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.

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**PERSONAL INFORMATION**

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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

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### HEALTH INFORMATION

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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? \_\_\_\_\_

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### REASON FOR CONSULTING OUR OFFICE

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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 \_\_\_\_\_

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: \_\_\_\_\_

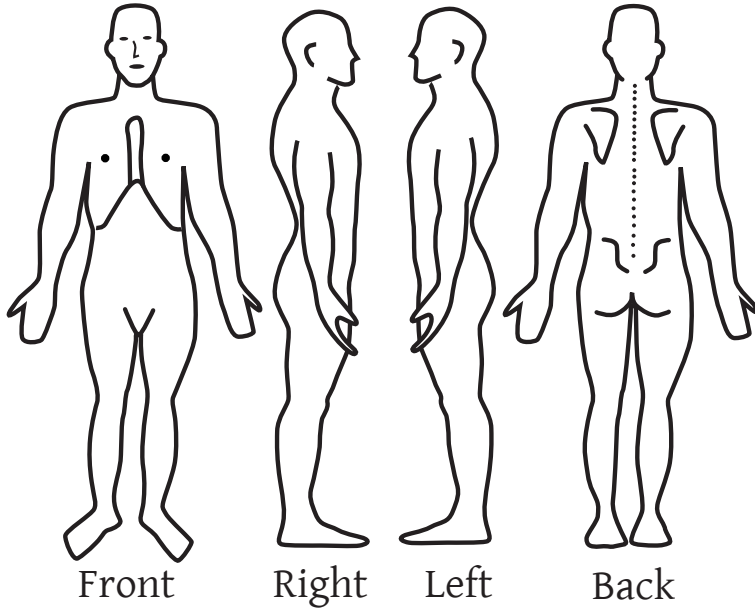
Have you had any other personal injury or accident:

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:



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

Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low Back pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	High blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Neck pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Digestive Upset	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Females Only:	
Allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Painful menstruation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heartburn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	PMS	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sore Throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Migraines	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Are you pregnant?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Patient's Signature: \_\_\_\_\_ Dated: \_\_\_\_\_