Spine FOCUS
chiropractic & rehab services

Required for Your Case History File: All Information Is Confidential

Full Name Mr/Mrs/Miss/Ms/Dr_____Name you prefer_____

Date Of Birth_____Occupation_____

Mailing Address_____

Telephone (Home)_____Mobile_____

Email_____Fax_____

Emergency Contact_____Telephone_____

Referred by_____Private Health Fund_____

Past chiropractic care? Yes❑ No❑ If yes, who? _____

Who is your General Practitioner (GP)? _____

What medications/vitamins/herbs are you taking?_____

Previous serious illness/ hospitalization: (Please date & describe) _____

Have ever had: Surgery Yes❑ No❑ Fractures Yes❑ No❑ Car Accidents Yes❑ No❑

Falls Yes❑ No❑ On-Job Injury Yes❑ No❑ Describe: _____

Family history of: Heart disease Yes❑ No❑ Cancer Yes❑ No❑ Diabetes Yes❑ No❑

Arthritis Yes❑ No❑ Back problems Yes❑ No❑ Other_____

If you are female, are you possibly pregnant? Yes❑ No❑

Major Symptom/Problem for this visit _____

Date symptoms first began _____

How did your symptoms first begin? _____

What activities aggravate your condition?_____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day?_____

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Is this condition interfering with work? Yes❑ No ❑ sleep? Yes❑ No ❑ routine? Yes❑ No

Other doctors seen for this condition _____

List home remedies tried _____

Do you have any of the following?

Constitutional
___ Unexplained Weight Loss
___ Fatigue or Weakness
___Fever

Eyes
___Glaucoma
___Cataracts
___Double Vision

Ears, Nose, Throat
___ Difficulty Hearing
___Buzzing or Ringing in Ears
___Dizziness
___ Loss of Smell
___Sinus Trouble
___ Difficulty Swallowing
___Loss of Taste

Skin
___Rashes
___Hives
___Itching

Allergic/Immunologic
___Hives/Hay Fever

Respiratory
___Cold/Flu/Cough
___Coughing Blood
___Wheezing

Gastrointestinal
___Nausea or Vomiting
___Constipation
___Diarrhea
___Digestive Problems

Genitourinary
___Blood in Urine
___Bladder Leakage
___Burning/Frequent Urination

Musculoskeletal
___Spinal Pain
___Joint Swelling
___Joint Stiffness

Cardiovascular
___Chest Pain
___Shortness of Breath
___Racing Heartbeat
___Fainting Spells

Neurological
___Headaches
___Memory Loss
___Tremors
___Numbness
___Loss of Strength
___Seizures

Mental Status
___Anxiety/Depression
___Mood Swings
___Difficult Sleeping
___Stress

Endocrine
___Loss of Hair
___Heat/Cold Intolerance
___Diabetes
___Excessive Sweating
___Change in Appetite

Hematologic/Lymphatic
___Ease of bruising
___Gums Bleed Easily
___Enlarged Glands

Check if you have had any of the following symptoms in the last 30 days:

Pain worse at night ❑ Constant pain unrelated to motion ❑ Unexplained weight loss ❑
Loss of bowel or bladder control ❑ Bacterial infection ❑ Surgery ❑ Fever or chills ❑

Check if you have ever had any of the following:

History of Cancer ❑ History of HIV ❑ Use of Steroids ❑ Use of IV Drugs ❑ Blood Transfusions ❑

*NOTICE TO NEW PATIENTS: In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between practitioners within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Signature_____Date_____form 105