

Name _____ Account # _____

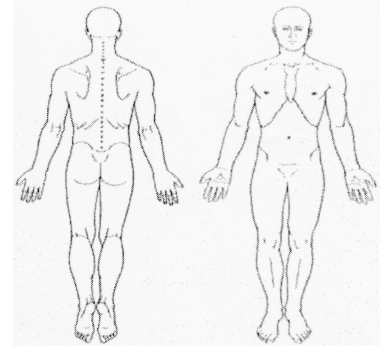
1- Please describe the **condition(s)** that brought you to this office, beginning with your highest **priority** (A) to lowest (C). If you have no health concerns please write "wellness checkup."

A _____

B _____

C _____

Please mark where you have your symptoms.



2- Circle the severity of your problem 1 = No Pain 10 = Very Severe

Neck right - left - both 1 2 3 4 5 6 7 8 9 10

Mid Back right - left - both 1 2 3 4 5 6 7 8 9 10

Low Back right - left - both 1 2 3 4 5 6 7 8 9 10

Arms right - left - both 1 2 3 4 5 6 7 8 9 10

Legs right - left - both 1 2 3 4 5 6 7 8 9 10

Other _____ 1 2 3 4 5 6 7 8 9 10

3- **Circle** the **sensations** you are experiencing. Sharp Pain - Burning - Dull Pain - Tingling - Throbbing - Cramping - Numbness - Stiffness - Aching - Swelling - Shooting - Stabbing

4- How **often** do you experience your problem? Constantly - 75% time - 50% time - Less than 25%

5- What **date & how** did your problem begin? _____

6- Did this result from an **injury** or accident at: home - work - car accident - other - no injury

7- Has your **condition**: improved - gotten worse - stayed the same

8- What makes your problem **worse**: walking - standing - sitting - movement - twisting - lifting - sneezing - coughing - bending - lying - other: _____

9- What makes your problem **better**? _____

10- Have you had this **before**? No - Yes when: _____ Treated by whom? _____

11- **What** treatment did you receive? _____ Date last treated: _____

12- **Results** of previous treatment: good - poor - comments: _____

13- What is this problem **interfering** with: work - sleep - daily routine - recreation - other: _____

14- What do you believe is **wrong** with you? _____

15- Name of last **Chiropractor** who treated you: _____

Date you were last seen: _____

16- Name of last **MD or DO** who treated you: _____

Date you were last seen: _____

17- **Females**: Is there any possibility that you are **pregnant**? No - Yes Date of last cycle: _____

18- **Other** health related **information** we should be aware of:

Signature _____ Today's Date: _____

I certify that the above information is accurate to the best of my knowledge.

Patient Case History – Koelling Family Chiropractic – 621 Commons Drive – Fulton, MO 65251