# Scott Chiropractic and Wellness

801-546-4500

180 W Gordon Ave, Layton, UT 84041 Confidential Health Information **Patient Case History**

Patient Name (print) _____ Case # _____

**1** What is your **primary complaint**? _____ Date Symptoms Started: _____

**Yes No**

☐ ☐ Have you ever had this same or similar condition? If yes, When _____ Describe _____

☐ ☐ Are you here because you were injured while: ☐ working ☐ vehicle collision ☐ another accident? If yes, check, Date_____

☐ ☐ Have you lost any days from work because of your **primary complaint**? If yes, LAST day of work OR list all _____

☐ ☐ Is this worse in the ☐ morning or ☐ evening? If yes, describe_____

☐ ☐ Is this getting worse? If no, is it ☐ CONSTANT or ☐ COMES AND GOES. Please check one, describe_____

☐ ☐ Does the pain progress into any extremity? ☐ Rt Arm ☐ Lt Arm ☐ Rt Leg ☐ Lt Leg ☐ All way to tip ☐ To first Joint _____

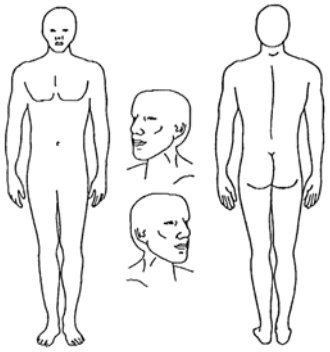
☐ ☐ Is the condition interfering with your ☐ WORK ☐ SPEEP ☐ DAILY ROUTINE - How much? ☐ A Little ☐ Moderately ☐ Quite a Bit ☐ Extremely

**2** What have you done for yourself? _____ **3** Has this helped? ☐ YES ☐ NO **4** Has anyone recommended surgery? ☐ YES ☐ NO

**5** Who else have you seen for this problem? ☐ Chiropractor ☐ Primary Care ☐ ER ☐ Neurologist ☐ Orthopedist ☐ Physical Therapist ☐ No One

**6** What do you believe is the cause of this problem? _____ **7** How long has it been since you felt really good?_____

**8** Circle ALL areas of pain / symptoms you are presently suffering with – draw a line to the severity of pain, check the frequency of pain:



**Circle the # to rate the severity of pain** **Frequency of the pain**

**"0" No pain at all "10" unbearable pain** **0-25% 25-50% 50-75% 75-100%**

0 1 2 3 4 5 6 7 8 9 ☐ Occasional ☐ Intermittent ☐ Frequent ☐ All the Time

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Check the type(s) of pain – ☐ Sharp ☐ Achy ☐ Stabbing ☐ Burning ☐ Numb ☐ Tingly
☐ Dull ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion ☐ Electric-like with motion

What makes this problem worse? _____ What alleviates this problem? _____

☐ ☐ Have you had any serious illness or hospitalizations in last five years? If yes, describe_____

☐ ☐ Are you currently taking prescription medications, list all _____

☐ ☐ Are you wearing ☐ **heel lifts**, ☐ **sole lifts**, ☐ **inner sole** ☐ **arch supports**? If yes, please check, reason _____

☐ ☐ Have you ever received chiropractic care before? If yes, When _____ Reason _____ Dr._____

What were the results? ☐ Great ☐ Good ☐ Fair ☐ Mixed ☐ Poor ☐ Other

**Please check all that apply: P – Past and N - Now**

| Past Now | Past Now | Past Now |
|---|---|---|
| ☐ ☐ Headaches | ☐ ☐ High Blood Pressure | ☐ ☐ Diabetes |
| ☐ ☐ Neck Pain | ☐ ☐ Low Blood Pressure | ☐ ☐ Excessive Thirst |
| ☐ ☐ Upper Back Pain | ☐ ☐ Heart Attack | ☐ ☐ Smoking / Tobacco Use |
| ☐ ☐ Mid Back Pain | ☐ ☐ Chest Pain | ☐ ☐ Drug / Alcohol Dependence |
| ☐ ☐ Low Back Pain | ☐ ☐ Angina | ☐ ☐ Loss of Consciousness |
| ☐ ☐ Shoulder Pain | ☐ ☐ Dizziness | ☐ ☐ Muscular Incoordination |
| ☐ ☐ Elbow-Upper Arm Pain | ☐ ☐ Slurred Speech | ☐ ☐ Dermatitis / Rash / Eczema |
| ☐ ☐ Wrist Pain | ☐ ☐ Stroke | ☐ ☐ Gallbladder / Liver Disorder |
| ☐ ☐ Hand Pain | ☐ ☐ Kidney Disorders | ☐ ☐ Hepatitis |
| ☐ ☐ Hip Pain | ☐ ☐ Kidney Stones | ☐ ☐ Poor Digestion |
| ☐ ☐ Upper Leg Pain | ☐ ☐ Bladder infections | ☐ ☐ Visual Disturbances |
| ☐ ☐ Knee Pain | ☐ ☐ Painful Urination | ☐ ☐ Epilepsy |
| ☐ ☐ Ankle / Foot Pain | ☐ ☐ Frequent Urination | ☐ ☐ HIV / AIDS |
| ☐ ☐ Jaw Pain | ☐ ☐ Loss of Bladder Control | |
| ☐ ☐ Joint Pain / Stiffness | ☐ ☐ Prostate Problems | |
| ☐ ☐ Spinal curvatures | ☐ ☐ Abnormal Wt Gain | |
| ☐ ☐ Arthritis | ☐ ☐ Abnormal Wt Loss | **FEMALES ONLY:** |
| ☐ ☐ Rheumatoid Arthritis | ☐ ☐ Loss of Appetite | ☐ ☐ Cramps or backache |
| ☐ ☐ Cancer | ☐ ☐ Abdominal Pain | ☐ ☐ Excessive menstruation |
| ☐ ☐ Tumor | ☐ ☐ Ulcer | ☐ ☐ Hot flashes |
| ☐ ☐ Chronic sinusitis | ☐ ☐ Depression / Bipolar | ☐ ☐ Irregular cycle |
| ☐ ☐ Asthma / Allergies | ☐ ☐ General Fatigue | ☐ ☐ Lumps in Breast |
| ☐ ☐ Rapid heart beat | ☐ ☐ Anxiety | ☐ ☐ Harmone Replacement |

**For Women ONLY**

☐YES ☐NO Are you pregnant? If yes, what month____

☐YES ☐NO Are you taking birth control pills?

I have been informed that X-Rays can be hazardous to an unborn child. To the best of my knowledge, I am not pregnant. I do consent to having X-Rays taken.

Signature_____

**Please Check Desired Results:**

☐ Intensive Care for temporary pain relief only.
☐ Corrective Care to stabilize function and promote healing.
☐ Wellness care to maintain increased body function.
☐ Specific nutritional evaluation, vitamin supplementation.

Indicate if you have any immediate family members with ☐ Diabetes ☐ Cancer ☐ Rheumatoid Arthritis ☐ Lupus ☐ ALS ☐ Heart Problems

Who is your primary care physician? _____

Anything else pertinent: _____

Patient Signature _____ Date _____

Guardian if under 18