

# Mink Chiropractic Center

409 Northside Drive  
Valdosta, GA 31602  
(229-242-3042)

Doctor \_\_\_\_\_

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

Type \_\_\_\_\_

Patients Name: _____	Social Security # _____
Address: _____ _____	Home Phone: _____
	Cell Phone: _____
Email: _____	Work Phone _____
Date of Birth: _____ Age: _____	Male _____ Female _____ Marital Status: M S W D
Occupation: _____	Employer: _____
Spouse's Name _____	Spouse's Occupation _____
Parent or Guardian if Minor _____	Referred by _____
Chief Complaint _____	

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? \_\_\_ Yes \_\_\_ No

Family Physician: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Person to contact in case of emergency (Name, Phone & Relationship) \_\_\_\_\_

What operations have you had? \_\_\_\_\_ When? \_\_\_\_\_

\_\_\_\_\_ When? \_\_\_\_\_

Serious Illness: \_\_\_\_\_ When? \_\_\_\_\_

\_\_\_\_\_ When? \_\_\_\_\_

What medications or drugs are you taking? (check those that apply): Pain Killers \_\_\_ Insulin \_\_\_ Cholesterol Meds \_\_\_

Blood Pressure Meds \_\_\_ Muscle Relaxers \_\_\_ Birth Control \_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_

Are you on a vitamin or Nutrition Program? Yes \_\_\_ NO \_\_\_

If so describe:

\_\_\_\_\_

What is your goal in our office? \_\_\_\_\_

Name \_\_\_\_\_

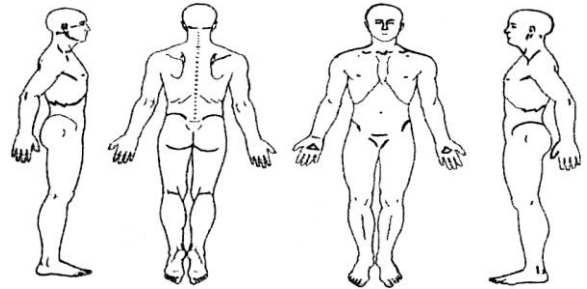
# CASE HISTORY

1. Circle the severity (1 = No Pain to 10 = Very Severe Pain) and the Frequency of your pain (% of the day you experience the pain).

(Please list your conditions on the lines below and rate them from top to bottom in the order of severity)

Condition	Severity		Frequency (% of day)																	
	Minimal	Severe	Occasional					Constant												
_____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100																	
_____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100																	
_____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100																	
_____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100																	
_____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100																	
_____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100																	
_____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100																	

Please circle the areas on the right figures where you experience pain.



2. When did your symptoms begin? \_\_\_\_\_

3. Has your condition? Improved \_\_\_ Gotten Worse \_\_\_ Stayed the same since its onset \_\_\_

4. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting

5. Is there anything you can do to relieve the problems? No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

If No, what have you tried that has not helped? \_\_\_\_\_

6. Have you been treated for this before? No \_\_\_ Yes \_\_\_ How long ago? \_\_\_\_\_

7. What treatment did you receive? \_\_\_\_\_

8. Results of previous treatment? Good \_\_\_ Poor \_\_\_ Comments \_\_\_\_\_

9. Is this condition interfering with Work \_\_\_ Sleep \_\_\_ Daily Routine \_\_\_ Recreation \_\_\_

10. Approximate date of last Chiropractic treatment? \_\_\_\_\_

11. Approximate date of last MD / DO treatment? \_\_\_\_\_

12. List any other major injuries you have had other than those that might have been mentioned above: \_\_\_\_\_

13. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes \_\_\_ No \_\_\_. If yes, Please explain \_\_\_\_\_

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

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_

