

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 _____

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 _____

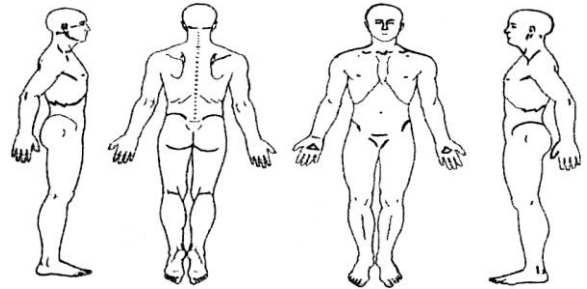
CASE HISTORY

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: _____

