MURRAY **CHIROPRACTIC** GROUP

CONFIDENTIAL CASE HISTORY

Date:_____

PERSONAL INFORMATION:

Last Name _____First Name _____
Do you prefer: ☐ First name ☐ Mr ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr ☐ Other _____
Address _____City _____ Prov._____ Postal _____
Birth date; M:____ D:____Y:_____ Age____ Marital Status; ☐M ☐S ☐W ☐D
Home Tel. _____ Cell Phone_____ Work Tel. _____
Occupation _____Employer _____
Spouse's Name _____ Children's Name _____
What occupies your spare time? _____
Who referred you to our office?_____
Name of regular Medical Doctor _____
Email Address _____

HEALTH INFORMATION:

Have you had previous chiropractic care? ☐ yes ☐ no When? _____ Why? _____

Have you ever had x-rays? ☐ yes ☐ no For what reason? _____

What is your major complaint? _____

How long have you had this condition? _____Have you had it before? ☐ yes ☐ no

What aggravates your condition _____

Is it getting: ☐ Better ☐ Worse ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other _____

How long has it been since you really felt good ? _____

Others who treated this condition: _____

List surgical conditions and years: _____

Drugs you now take: ☐ Pain killers ☐ Muscle relaxants ☐ Birth control ☐ Vitamins ☐ Other _____

_____

Are you wearing: ☐ Heel lifts ☐ Orthotics ☐ Special supports or braces _____

Have you ever been in an automobile accident? ☐ Never ☐ Past year ☐ Within 5 years ☐ More than 5 years ago Describe: _____

Have you ever had any other personal injury or accident? ☐ yes ☐ no Describe: _____

REASON FOR CONSULTING THE OFFICE:

☐ I have a specific problem and only require help with this problem.
☐ After my problem has been relieved, I am interested in strategies to ensure the problem does not return.
☐ Spinal checkup and to improve my general health.

HEALTH HISTORY:

To provide us with a more complete clinical picture, please answer the following questions, even if you do not think they are related to your health problem. Pain is often referred from other areas or it may be related to a more serious underlying pathology.

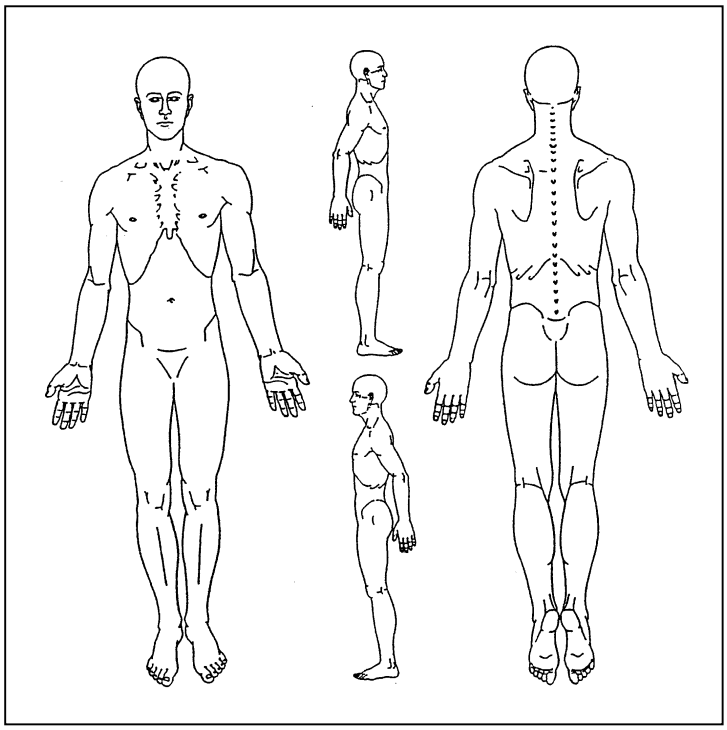
Have you ever suffered from:

1. Dizziness ☐ Yes ☐ No
2. Heart trouble ☐ Yes ☐ No
3. Diabetes ☐ Yes ☐ No
4. Arthritis ☐ Yes ☐ No
5. Asthma ☐ Yes ☐ No
6. Cancer ☐Yes ☐ No
7. Digestive problems ☐Yes ☐ No
8. Numbness ☐ Yes ☐ No
9. Tingling ☐ Yes ☐ No
10. Bladder trouble ☐ Yes ☐ No
11. Kidney trouble ☐ Yes ☐ No
12. Backaches ☐ Yes ☐ No
13. Neck pain ☐ Yes ☐ No
14. Headaches ☐ Yes ☐ No

FEMALES:

1. Severe menstrual pain ☐ Yes ☐ No
2. Vaginal pain ☐ Yes ☐ No
3. Breast pain ☐ Yes ☐ No
4. Lumps on breast ☐ Yes ☐ No

Please mark the main areas of pain on the figures below:



Make a mark (/) along the line which you think represents your current level of pain in your major area of injury, somewhere between “No Pain at all” and “Severe Pain”

_____

No Pain at all Severe Pain

FAMILY HEALTH INFORMATION (Past or present health problems):

Mother: _____

Father: _____

Siblings: _____

Type of Coverage: ☐ MSP ☐ WCB ☐ ICBC ☐ Other: _____

Medical Number: _____