Woodroffe Chiropractic Clinic
& MASSAGE THERAPY

CONFIDENTIAL CASE HISTORY

Your answers will help us determine if our care can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

DATE:

PERSONAL INFORMATION

Name: _____ **E-MAIL:** _____

How do you wish to be addressed in our office? ☐ First Name ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr.
Address: _____ City: _____
Postal Code: _____ Home Phone: _____ Business _____
Date of Birth: yy____mm____dd____ Cell Phone _____
Employer: _____ Address: _____
Occupation: _____
Spouse/Partner's Name:_____ How many children do you have? (Age and Gender)
Who may we thank for referring you to our office? _____
How did you hear about us? If it was "Google", tell us what you typed as a search term. _____

OTHER PROVIDERS

Have you consulted a chiropractor previously? Y N Chiropractor's Name: _____
When was your last visit? _____ What was the problem?_____
Was the experience a good one? Yes No
Family Doctor's Name: _____ Address: _____ Tel: _____
May we send progress notes to your family doctor? No Yes your initials here if "yes"

REASON FOR CONSULTING OUR OFFICE

Stress Symptoms
- ☐ Headache/Migraine
- ☐ Dizzy
- ☐ Ringing in ears
- ☐ Blurring of vision
- ☐ Poor concentration
- ☐ Loss of sleep
- ☐ Depression
- ☐ Decreased energy
- ☐ Irritability

Females Only!
- ☐ Painful menses
- ☐ Irregular menses
- ☐ Fibroids

Muscle/Joint/Bone
- ☐ Backache
- ☐ Neck pain
- ☐ Arm/hand pain or tingling
- ☐ Leg/foot pain or tingling
- ☐ Tension/pain in shoulders
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Osteoarthritis

Digestive
- ☐ Gall bladder pain
- ☐ Heartburn
- ☐ Constipation
- ☐ Loose stool
- ☐ Stomach pains

Neurological
- ☐ Seizures
- ☐ Fainting
- ☐ Convulsions
- ☐ Loss of balance
- ☐ Vertigo
- ☐ Tremors

Ears Nose Throat
- ☐ Earache
- ☐ Sinus trouble
- ☐ Chronic runny nose
- ☐ Allergies
- ☐ I am a smoker
- ☐ Cancer in my history
- ☐ Cancer in my family

Cardiorespiratory
- ☐ Asthma
- ☐ Chest pain
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Heart palpitations
- ☐ Racing heart
- ☐ High blood pressure
- ☐ Stroke / Heart attack

Genitourinary
- ☐ Painful voiding of bladder
- ☐ Blood in urine
- ☐ Urgency
- ☐ Enlarged prostate

List any prescription drugs you are taking. _____

Are you pregnant? Circle one. Yes No

I hereby consent to a hands-on physical examination. I also certify that the information I have provided is true and complete.

Patient Signature: _____ **Date:** _____

Name: _____

1. Pain Intensity

No pain | Mild pain | Moderate pain | Worst possible

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc)

No pain, no restrictions	Mild pain but no restrictions	Moderate pain: moving slowly	Moderate pain: need some assistance	Severe pain: need 100% assistance

4. Travel (driving , riding bus etc.)

No pain on long trips.	Mild pain on long trips.	Moderate pain on long trips	Moderate pain on short trips.	Severe pain on short trips.

5. Work

Can do usual work plus unlim-ited extra work.	Can do usual work but no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain | Mild pain | Moderate pain | Worst possible

7. Frequency of Pain

No pain	Occasional pain: 25% of day	Intermittent pain: 50% of day	Frequent pain: 75% of day	Constant pain 100% of day

8. Lifting

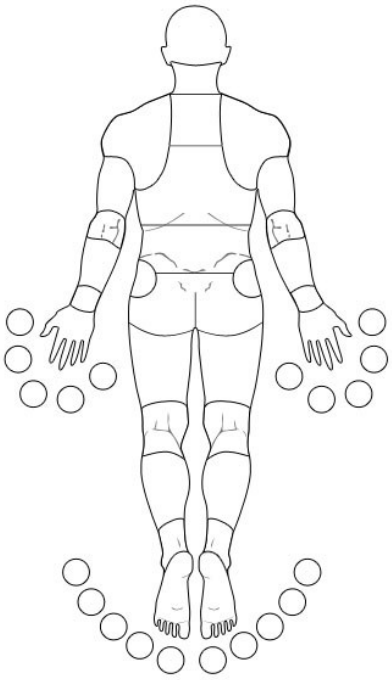
No pain w/ heavy weight	Increased pain w/ heavy weight	Increased pain w/ moderate weight	Increased pain w/ light weight	Increased pain w/ any weight

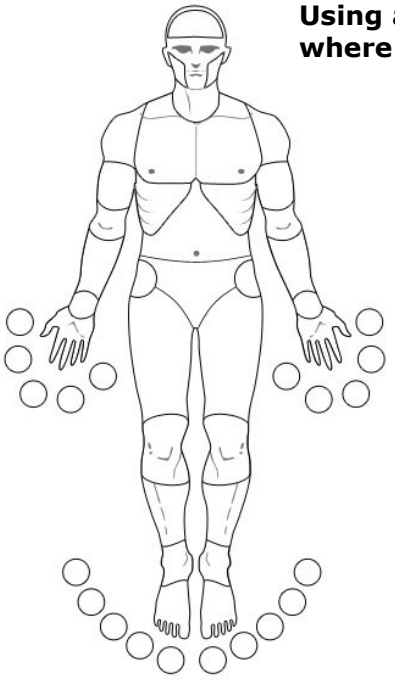
9. Walking

No pain any distance	Increased pain after 1 km	Increased pain after 1/2 km	Increased pain after 250m	Increased pain all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 30 min	Increased pain w/ any standing





Using a pen, carefully show us where your symptoms are.

Woodroffe Chiropractic Clinic

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