KENT SPORT & SPINE
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CONFIDENTIAL CASE HISTORY FILE

Date: _____

Full Legal Name: _____ **Name you prefer:** _____

Address: _____ **City/State/Zip** _____

Phone: (home) (____) _____ **(work)** (____) _____ **Soc Sec#** ____ - ____ - ____

Birth date: ____/____/____ **Age:** _____ **Sex:** _____ **Marital Status:** S M W D Sep

Spouse's Name: _____ **# Children** _____ **Years of Education** _____

Emergency Contact: _____ **Phone:** (____) _____

Your Employer: _____ **Phone:** (____) _____

Employer's Address: _____ **City/State/Zip** _____

Job title: _____ **Supervisor Name:** _____

e-mail address: _____ **Referred by:** _____

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

_____

List all current over-the-counter and prescription medications used (include reason used):

_____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

_____

Have you been under a physician's care in the past year? ☐ no ☐ yes (reason) _____

When was your last physical examination? _____ **Dr:** _____

Have you ever been under chiropractic care? ☐ no ☐ yes (describe) _____

If female, is there a possibility that you are pregnant? ☐ no ☐ yes

Do you smoke/use tobacco? ☐ no ☐ yes **Exercise habits?** ☐ never ☐ occasional ☐ frequent

Check any of the following symptoms you have noticed: (■ = Previously, ☐ = Now)

■ ☐ Headaches	■ ☐ Low back pain	■ ☐ Sensitive to light or sound
■ ☐ Dizziness or light-headed	■ ☐ Leg/foot numbness/tingling	■ ☐ Visual or hearing disturbance
■ ☐ Jaw pain, clicking, or locking	■ ☐ Leg/foot fatigue/weakness	■ ☐ Memory loss/problems
■ ☐ Pain or difficulty swallowing	■ ☐ Leg pain with walking	■ ☐ Irritability or depression
■ ☐ Neck pain or stiffness	■ ☐ Abdominal pain	■ ☐ Fatigue or loss of energy
■ ☐ Shoulder pain	■ ☐ Nausea or vomiting	■ ☐ Fainting or convulsions
■ ☐ Mid back pain	■ ☐ Diarrhea or constipation	■ ☐ Trouble with balance or coordination
■ ☐ Chest pain or cough	■ ☐ Blood in urine or stool	■ ☐ Sleep disturbances/problems
■ ☐ Pain/trouble breathing	■ ☐ Difficulty or pain w/ urination	■ ☐ Rashes (face, body, limbs)
■ ☐ Arm/hand numbness/tingling	■ ☐ Difficulty with sexual function	■ ☐ Joint pain or swelling
■ ☐ Arm/hand fatigue/weakness	■ ☐ Abnormal menstrual periods	■ ☐ Pain with exertion (activity, climbing stairs, etc.)

HAVE YOU HAD *ANY* OF THE FOLLOWING:

NOW:
- ☐ Pain worse at night
- ☐ Constant pain
- ☐ Unexplained weight loss
- ☐ Recent bacterial infection (30 days)
- ☐ Loss of bowel or bladder control
- ☐ Urinary discharge
- ☐ Recent surgery (30 days)

EVER:
- ☐ History of cancer
- ☐ History of IV drug use
- ☐ History of blood transfusion