Dr. David Kreinbrook Chiropractor

Patient Case History

File:_____

Name:_____ **Date:**_____
Address:_____**City:**_____**State:**_____
Zip: _____**Home#:**_____
Cell #:_____ **Cell Provider**(For text reminders):_____
Email Address:_____
Date of Birth: ____/_____/_____ **Age:**_____ **If a minor, parents name:**_____
Your Occupation:_____ **Employer**:_____
Marital Status:_____ **Spouse's Name**: _____
Spouse's Occupation:_____ **Employer:**_____
Names of Children and Ages: _____/ _____
_____/ _____/ _____
Who referred you to our office? _____
Have you Ever Received Chiropractic Care? YES NO
When: _____ **Where**: _____
Were X-rays Taken? YES NO Year: _____

Core Problems/Complaints/Symptoms: (Example: Low back pain, Left knee…)

1: _____ **2:**_____

3: _____ **4:**_____

Symptoms and Health: Any of the following symptoms may be signs of abnormal spinal cord tension due to Subluxations. **Please read carefully and check past and present symptoms.**

- Cold Sweats
- Headache
- Face Flushed
- Neck Pain
- Stiff Neck
- Numbness in Toes
- Pins and Needles in Legs
- Pins and Needles in Arms
- Cold Hands
- Cold Feet
- Shortness of Breath
- Lights Bother Eyes
- Loss of Memory
- Loss of Balance
- Loss of Smell
- Loss of Taste
- Ringing in Ears
- Buzzing in Ears
- Dizziness
- Nervousness
- Tension, Stress
- Anxiety
- Irritability
- Anger Easily, Frustration
- Fatigue
- Depression
- Fainting
- Chest Pain
- Stomach Upset
- Diarrhea
- Constipation
- Sleeping Problems
- Lack of Motivation
- Allergies
- Sinus Problems

When your pain is at its worst, how does it affect or interfere with your normal activities?

Self- Care: Is this interfering with your ability to dress, shower, drive the car, fall or stay asleep?

_____

Recreation: Has this limited your ability to participate in hobbies, sports, physical fitness or other leisure time activities?

_____

Work or School: Has this made you less effective or productive at work or school? If yes, have you missed any days?

_____

Family and Home Responsibilities: Has this limited your ability to do house chores, yard work, grocery shopping, caring/playing with the children, or your relationship with loved ones?

_____

What is your #1 goal with treatment? _____

Present reasons for visiting our office or how do you want us to handle your problem?

_____ I want **temporary relief**, just help with symptoms, however, I know it may not correct the problem.

_____ I want **maximum correction**, correcting the cause of the problem, if possible, for maximum stability.

Have you been under any medical care? **YES** **NO**

What medications are you currently taking? _____

_____

Have you had any prior surgeries? **YES** **NO** What and When?

_____

_____

Any side effects from the drugs and surgery? _____

Heart Attack? **YES** **NO** **When?**_____

Stroke? **YES** **NO** **When?**_____

Aneurysm **YES** **NO** **When?**_____

Have you had any accidents, falls or injuries in your lifetime? **YES** **NO**

When? What happened? _____

_____

_____

Family Health History:

Heart Disease [ ] Mother [ ] Father

Diabetes [ ] Mother [ ] Father

Arthritis [ ] Mother [ ] Father

Cancer [ ] Mother [ ] Father

Other _____ _____