File #:	_
Date:	_
Postal Code:	
	_
	_
ointment	
ppointment	
symptoms in the past?	
etter 🗆	
Use Only:	
aktion for the con-	
ating factors:	
ng factors:	
is chiropractic care:	
History:	

## **CASE HISTORY**

Name:	Email:
Address:	Postal Code:
Phone:	Cell:
Gender: Birthdate:	PHN:
Appointment Reminder: YES □ NO □ □ Phone call 24 hrs before appointment □ Toyt or Email 24 hrs before appointment	
	Text of Email 2 days before appointment
	Have you experienced similar symptoms in the past?
If 'YES', please describe:	
	se □ staying the same □ getting better □
Have you recently experienced the followi	ing - please check YES or NO Office Use Only:
History of cancer  Fevers  Weight loss (unexplained)  Pain that wakes you up  Significant Cortisone use  Recent infection  Diabetes	
Type of pain <i>(circle)</i> Where d	o you hurt? <i>(circle)</i>
Numbness  Tingling  Dull ache  Stabbing  Shooting	Aggravating factors:  Relieving factors:
To help us track of your progress, please list walking, reaching etc.) you are either unable difficulty performing due to your chief probledifficulty from 0-10.  O = No difficulty	e to perform or are having
Daily Activities Difficult to Pe	
1	
2	
3	