Mantini Chiropractic and Wellness Center
330 Main Street
Ford City, PA 16226
724-763-1238

Chiropractic Case History

Name_____Sex M F Marital Status M S D W Date_____

Address_____ State_____Zip_____

Home Phone_____Cell Phone_____ Date of Birth_____Age_____

Referred by_____Social Security #_____

Occupation_____ Employer_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

1. Primary reasons for seeking chiropractic care:

Primary reason/Chief complaint:_____

Secondary reason: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

4. Past Health History:
A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

Females – Is there any possibility you are pregnant? Y or N

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____

REVIEW OF SYSTEMS

CONSTITUTIONAL (fever, weight loss or gain, tired feeling)	yes	no	_____
EYES (blurred vision, eye pain, discharge, etc)	yes	no	_____
EARS, NOSE, THROAT, AND MOUTH (hearing loss Earache, nasal congestion, chronic cough, nasal drip, dry mouth)	yes	no	_____
RESPIRATORY (asthma, emphysema, wheezing, chronic Bronchitis, shortness of breath, etc.)	yes	no	_____
CARDIOVASCULAR (diabetes, hypertension, heart problems)	yes	no	_____
GASTROINTESTINAL (diarrhea, constipation, hernia, ulcer)	yes	no	_____
GENITOURINARY (painful urination, frequent urination, Impotence, jaundice, etc)	yes	no	_____
LYMPHATIC (anemia, bleeding problems, blood transfusions)	yes	no	_____
MUSCULOSKELETAL (arthritis, joint pain, muscle pain, cramps Stiffness, swelling, etc)	yes	no	_____
SKIN (pimples, warts, growths, rashes, etc)	yes	no	_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

Revised 11/21/2012