

Brewer Chiropractic Clinic
702 IH 20W, Suite 100
Arlington, TX 76017
(817) 467-2010

Case History

Name _____ ☐ Male ☐ Female Age: ____ Date: _____
Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when? _____

Complaint / Condition

1. **Primary Complaint** _____

Complaint began when? _____ Duration of complaint? _____

Have you had this before? ☐ yes ☐ no How did you hurt yourself? _____

Is condition getting worse? ☐ yes ☐ no Condition interferes with _____

How frequent is it, and how long does it last? _____

Circle the Quality of the pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does any pain radiate or travel to any areas of your body? _____

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

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

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous doctors, treatments, medications, or surgery you've sought for your complaint: _____

2. **Secondary Complaints** _____

Past History

Previous illnesses you've had in your life _____

Previous injuries or trauma _____

Allergies _____

Medication: (you are currently taking)

Dose

Reason

Surgeries: Date

Type of Surgery

Females: Pregnancy, Date of Delivery

Outcome

Family Health History

Associated health problems of relatives _____

Deaths in immediate family – Who	Cause	Age at Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social & Occupational History

Level of Education ☐ High School ☐ Some College ☐ College Graduate ☐ Post Graduate Studies

Job Description _____

Work Schedule _____

Recreational activities _____

Level of Activity ☐ Sedentary ☐ Moderate ☐ Active ☐ Very Active

Lifestyle (hobbies, alcohol, tobacco and drug use, diet...) _____

Doctor's Notes

Signatures

I have read the above information and certify it to be true and correct of the best of my knowledge, and hereby authorize Brewer Chiropractic clinic to provide me with chiropractic care.

Patient or Guardian Signature

Date