Ashland Chiropractic Center, Inc. ~ Robert E. Bachelder, DC, DABCO
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CASE HISTORY

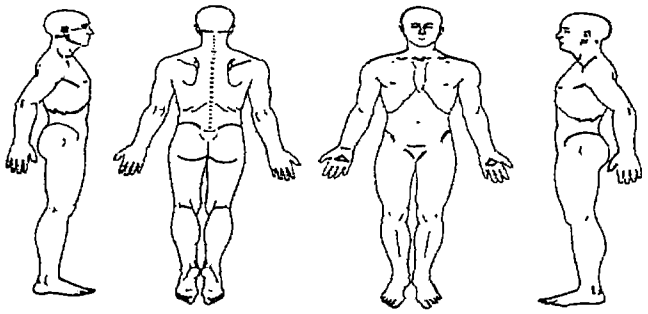
Name: _____ DOB: _____

Family Physician: _____ Phone Number: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
16. List any other major injuries/illness/operations you have had, other than those mentioned above: _____

_____

17. Have you had any *spinal* x-rays, MRI's or CT's taken in the last year? N/Y If so where? _____
18. Any other Musculoskeletal problems? ____No ____Yes ...Neurological problems? ____No ____ Yes
19. Do you have a **pacemaker**? ____No ____ **YES** Have you had any hip or knee replacements? ____No ____ Yes

20. What medications do you currently take? (please check all that apply)

Pain Killers ____ Insulin ____ Cholesterol Meds ____ Blood Pressure Meds ____ Muscle Relaxers ____

Birth Control ____ Other(s) _____

21. What is your goal in our office? _____

22. Please list anything else you feel the doctor should know: _____

_____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

If this form is completed by someone other than the patient, please list your relationship: _____