Phone: 860.648.2259

Family Wellness Center, LLC
469-D Buckland Road
South Windsor, CT 06074

CONNECTICUT chiropractic

Name ______________________ Date ______________ File ____________

CASE HISTORY

There is room on this page to list 2 different areas of complaint. If you have more than 2 areas of complaint, please ask for more forms.

COMPLAINT AREA 1

What is your current condition or problem?		Onset of problem?	Suddenly / Gradually
What caused the problem?		Date started?	
What makes the problem feel worse?			
What makes the problem feel better?			
How is the problem described?	Achy / Burning / Cold / Fatigue / Hot / Numb / Pins & Needles / Sharp / Tense / Weak / Other:		
Where is the primary site of the problem?			
Where does the problem refer to?	(For instance: Neck pain that refers to the right arm.)		
How often do you notice the problem?	Come and Go / Constant	When is the problem noticed?	Morning / Afternoon / Night
Other associated symptoms?			
What is the status of the condition?	Improving / Same / Worsening	Explain:	

COMPLAINT AREA 2

What is your current condition or problem?		Onset of problem?	Suddenly / Gradually
What caused the problem?		Date started?	
What makes the problem feel worse?			
What makes the problem feel better?			
How is the problem described?	Achy / Burning / Cold / Fatigue / Hot / Numb / Pins & Needles / Sharp / Tense / Weak / Other:		
Where is the primary site of the problem?			
Where does the problem refer to?	(For instance: Neck pain that refers to the right arm.)		
How often do you notice the problem?	Come and Go / Constant	When is the problem noticed?	Morning / Afternoon / Night
Other associated symptoms?			
What is the status of the condition?	Improving / Same / Worsening	Explain:	

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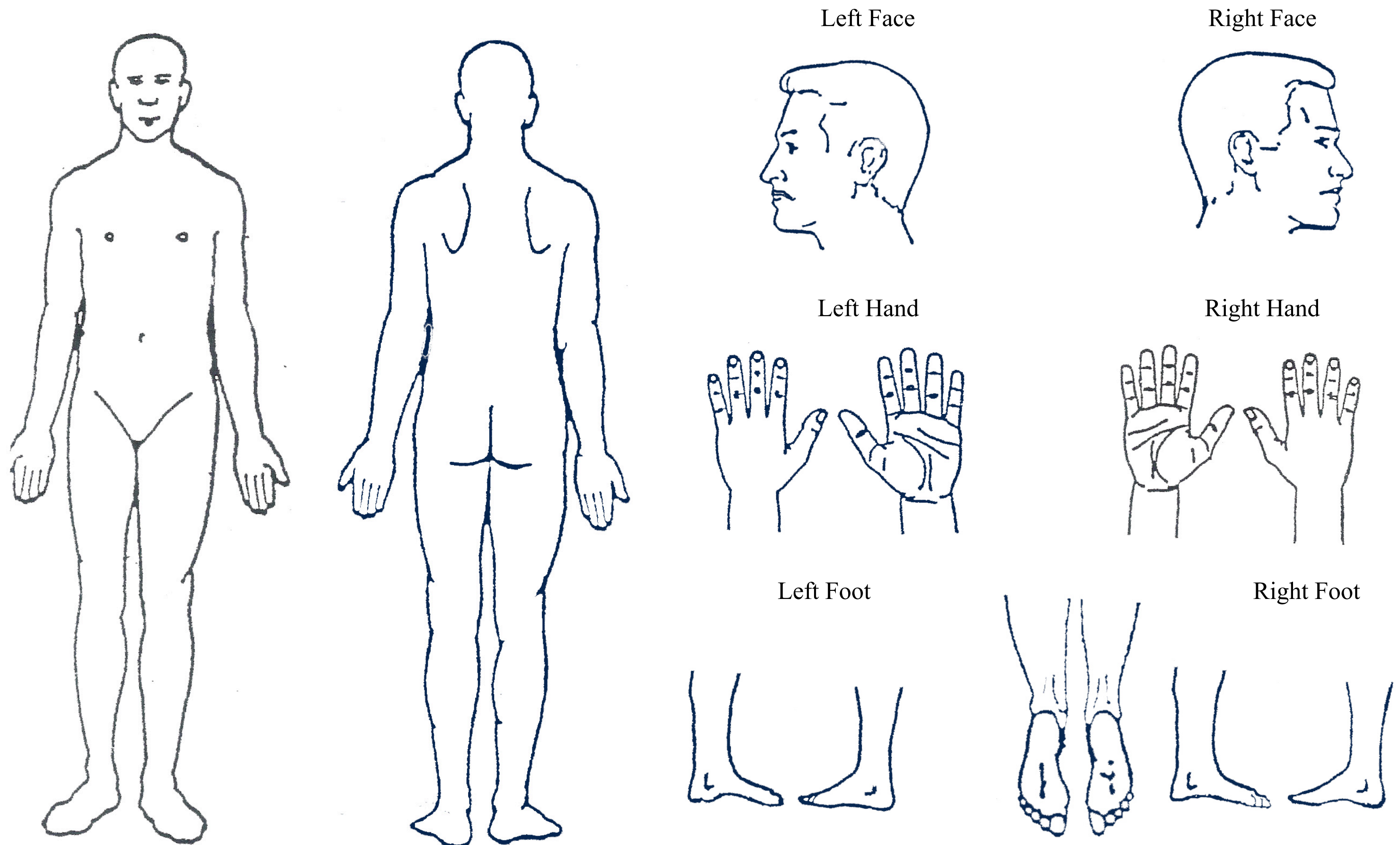
Symptom Drawing

Mark the areas on your body where you feel the following sensations.

Aches	^ ^ ^ ^	Cramping	C C C C	Pins & Needles	P N P N	Stabbing	/ / / /
Burning	X X X X	Numbness	+ + + +	Sensitive	S S S S	Other	O O O O



Rate the severity of your symptom(s) by marking "I" at the appropriate point on the line & grade the symptom from 0 to 10

(Example: 0 ______________ I ______________ 10)
No Symptoms 5 Worst Possible, Unbearable

( ) Rate your head symptom(s) now 0 ______________ 10
( ) Rate your neck symptom(s) now 0 ______________ 10
( ) Rate your mid back symptom(s) now 0 ______________ 10
( ) Rate your low back symptom(s) now 0 ______________ 10
( ) Rate your arm symptom(s) now 0 ______________ 10
( ) Rate your leg symptom(s) now 0 ______________ 10

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PAST HISTORY & SYSTEM REVIEW

Circle for PAST (P) or CURRENT (C) diseases, conditions or symptoms. Then explain in the description section on the next page.

Childhood			**Cardiovascular**			**Genitourinary**		
Chicken Pox	P	C	Heart Disease	P	C	Bladder disease	P	C
Measles	P	C	Arteriosclerosis	P	C	Kidney disease	P	C
Rubella	P	C	Murmur	P	C	Stones	P	C
Other	P	C	Stroke	P	C	Urinary tract infections	P	C
Constitutional			Varicose veins	P	C	Urination problems	P	C
Addiction (alcohol, smoke, etc.)	P	C	Arm &/or leg swelling	P	C	Urinate times per day	P	C
Habits (alcohol, smoke, etc.)	P	C	Chest pain / pressure / discomfort	P	C	**Male Reproductive**		
Eating Disorder	P	C	Cold hands &/or feet	P	C	Discharge. mass, sores, pain	P	C
General fatigue / weakness	P	C	High or low blood pressure	P	C	Prostate disease	P	C
Fever / chills	P	C	High cholesterol	P	C	Testicular disease	P	C
Eyes			Leg pains or cramps	P	C	Sexually transmitted disease	P	C
Cataract	P	C	Palpitations	P	C	**Female Reproductive**		
Glaucoma	P	C	**Respiratory**			Discharge. mass, sores, pain	P	C
Tears – excess or reduced	P	C	Lung disease	P	C	Ovary disease	P	C
Vision problems	P	C	Asthma	P	C	Uterus disease	P	C
Ears			Emphysema	P	C	Sexually transmitted disease	P	C
Ear infections / earaches	P	C	Pneumonia	P	C	Menstrual symptoms	P	C
Hearing loss	P	C	Chronic cough	P	C	Menstrual cycle # days		
Ringing	P	C	Difficult breathing / tightness	P	C	Birth Control	P	C
Nose			**Gastrointestinal**			Pregnancies		
Loss of smell	P	C	Esophagus disease	P	C	Deliveries		
Nasal discharge	P	C	Stomach disease	P	C	**Musculoskeletal**		
Nasal stuffiness	P	C	Gall bladder disease	P	C	Arthritis	P	C
Sinus			Liver disease	P	C	Braces, Supports, Orthotics	P	C
Sinusitis / infection	P	C	Intestinal disease	P	C	Gout	P	C
Polyps	P	C	Appendicitis	P	C	Muscle pain, swelling, tightness	P	C
Pain	P	C	Hemorrhoids	P	C	Joint pain, swelling, tightness	P	C
Mouth			Hernia	P	C	Neck pain	P	C
Dental disease	P	C	Peptic Ulcer	P	C	Mid-back pain	P	C
Gum disease	P	C	Bowel movement changes	P	C	Low back pain	P	C
Jaw click or mal-position	P	C	Bowel movement times per day			**Neurological**		
Loss of taste	P	C	Gas / belching / gripping	P	C	Neurological disease	P	C
Saliva – excess or reduced	P	C	Heartburn / constriction	P	C	Concentration problems	P	C
Grinding	P	C	Indigestion / nausea	P	C	Convulsions, seizures	P	C
Throat			Jaundice	P	C	Dizziness / fainting	P	C
Tonsil disease	P	C	Stools bloody / dark	P	C	Headache	P	C
Infections	P	C	Regurgitation / vomiting	P	C	Memory problems	P	C
Swollen glands	P	C	**Blood**			Migraine	P	C
Difficult swallowing	P	C	Anemia	P	C	Neuritis	P	C
			Bruise / bleed easy	P	C	Sleep problem (# hours)	P	C

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PAST HISTORY & SYSTEM REVIEW (Continued)

Circle for PAST (P) or CURRENT (C) diseases, conditions or symptoms. Then explain in the description section on the next page.

Integument (Skin)			**Endocrine**			**Any Other Conditions**		
Skin disease, rashes, sores	P	C	Endocrine glad disease	P	C		P	C
Eczema	P	C	Thyroid disease	P	C		P	C
Dryness	P	C	Diabetes	P	C		P	C
Psychological			Osteoporosis	P	C		P	C
Mental Illness	P	C	Appetite – excess or reduced	P	C		P	C
Depression	P	C	Sweating – excess or reduced	P	C		P	C
Mood swings	P	C	Temperature intolerance	P	C		P	C
Nervousness	P	C	Thirst – excess or reduced	P	C		P	C
Breasts			Weight change	P	C		P	C
Breast disease	P	C	**Immunity**				P	C
Discharge	P	C	Allergies	P	C		P	C
Lumps or dimpling	P	C	Cancer	P	C		P	C
Pain or discomfort	P	C	Cold sore	P	C		P	C
Self exam	P	C	Frequent colds	P	C		P	C
			Lyme’s disease	P	C		P	C

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DESCRIPTION OF PAST AND / OR CURRENT CONDITIONS

CONDITION	AGE	PAST CONDITION(S) BRIEFLY DESCRIBE (include – medicine, surgery, chiropractic, etc.)
CONDITION	AGE	CURRENT CONDITION(S) BRIEFLY DESCRIBE (include – medicine, surgery, chiropractic, etc.)

IMMUNIZATION HISTORY

Describe immunizations received over the past year: ______________________

____

____

____

HEALTH SCREENING HISTORY

Indicate the last time you were examined or screened for the following. (Leave blank if never, question mark if Date is unknown.)

Exam	**Date**	**Exam**	**Date**	**Exam**	**Date**	**Exam**	**Date**
History & Physical		Blood Pressure		Stool		Bone Density	
Breast		Pap Smear		Sigmoidoscopy		Body Composition	
Pelvic		Cholesterol		Mammogram		Diet	
Rectal		Venereal Disease		Prostrate		Exercise	
Hearing		PPD (TB)		Posture & Spine		Other:	

Results: ______________________

____

____

____

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DIETARY AND MEDICATION STATUS

DIETARY HABITS AND SOURCES

Describe your dietary habits: (# of meals, vegetarian, quantity of junk food, favorite foods, etc.)

____

____

____

Indicate the frequency of consuming foods from the following sources:

Grocery Store (Home)	Never	Rarely	Often	Usually	Always
Restaurant - Regular	Never	Rarely	Often	Usually	Always
Restaurant – Fast (McDonalds, Wendy's, etc.)	Never	Rarely	Often	Usually	Always

MEDICINES, SUPPLEMENTS

List all current medicines, nutrients, herbs, botanicals consumed

____

____

____

PHYSICAL ACTIVITY STATUS

Describe your physical activity level: (Low, medium, high – play, TV, computer, rest, sports, exercise, etc.)

____

____

____

HEALTH CARE PROVIDERS

List Health Care Providers currently seen for your current problem(s) and any condition.

Name, Address & Phone	Last Visit	Diagnosis	Treatment
1.			
2.			
3.			
4.			