Geise Chiropractic LLC
913 W Logan St, Celina, OH 45822
419-586-8600

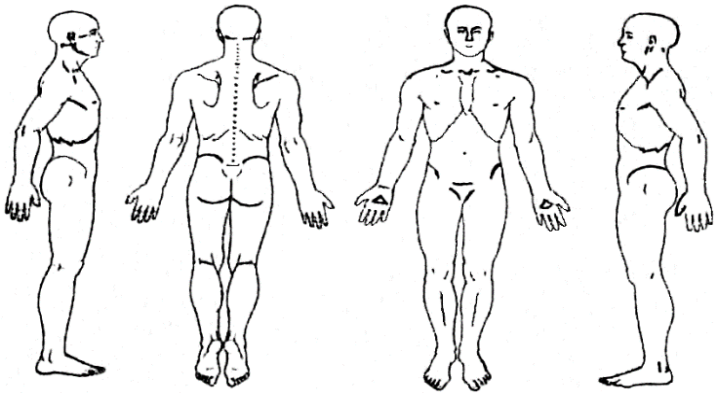
CASE HISTORY

Legal Name: _____ Preferred Name:_____ Date: _____

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

(Please mark the figures where you experience pain.)



2. **Symptoms are <u>worse</u> 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 / Tightness / Stiffness
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles / Tightness / Stiffness
5. Symptom (c.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles / Tightness / Stiffness
6. **How did your symptoms begin?** _____
7. **When did your symptoms begin (onset date)?** _____ **Have you experienced these before?** YES NO
8. **Do your symptoms radiate?** YES NO If yes, ARMS LEGS HEAD (circle one)
9. **Has your condition?** ____ Improved ____ Gotten Worse ____ Stayed the same
10. **<u>SINCE IT BEGAN Circle the activities that make your problems worse</u>**:

-BENDING -LYING -WALKING -STANDING -SITTING -MOVEMENT -TWISTING - LIFTING -FALLING ASLEEP

-STAYING ASLEEP -CONCENTRATING -DRIVING A CAR -RISING OUT OF CHAIR OR BED –LOOKING OVER SHOULDER

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

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

Additional information on back side of sheet.

12. Have you been treated for this before? ____No ____Yes How long ago? _____

13. What treatment did you receive? Chiropractic, Medical, Physical Therapy, Massage, Other_____

14. Results of previous treatment? ____Good ____Poor Comments _____

15. Were you referred to our office by anyone? _____

16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation

Family Physician: _____ (Note: May we send your health information to this **provider Y / N)**

Person to contact in case of emergency (Name, Relationship and Phone):

_____

Have you ever been under Chiropractic Care? Y N If so, Who / When? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

Serious Illness: _____ When? _____

Do you have a pace maker? Y / N

What medications or drugs are you taking? (check those that apply): Pain Killers Insulin Cholesterol Meds

Blood Pressure Meds Muscle Relaxers Birth Control Other: _____

Please circle to indicate whether you have had any of the following:

○ Alcoholism	○ Blood Pressure **High or Low**	○ Cancer Type:
○ Diabetes	○ Cholesterol Elevation	○ Depression / Anxiety
○ Epilepsy	○ Fractures Type:	○ GI Issues: Stomach / S1 / L1
○ Goiter	○ Headaches	○ Heart Disease
○ Kidney / Bladder Disease	○ Liver Disease	○ Lung Issues
○ Metal Implants Location(s):	○ Multiple Sclerosis / Strokes	○ Pancreatitis
○ Parkinson's Disease	○ Prostate Problems	○ Rheumatoid Arthritis
○ Spinal Stenosis: **Neck / Low Back**	○ Thyroid Problems: Hyper / Hypo	○ Ulcers
○_____	○_____	○_____

History of Surgeries: Please circle to indicate whether you have had any of the following:

○ Gall Bladder	○ Appendectomy	○ Heart	○ Abdomen	○ Hernia
○ Hip **L / R**	○ Knee **L / R**	○ Foot **L / R**	○ Rotator Cuff **L / R**	○ Carpal Tunnel Syndrome **L / R**
○ Joint Replacements: Shoulder **L / R** Knee **L / R** Hip **L / R**	○ Herniated Disc: **Neck / Low Back**	○Hysterectomy **Partial / Total**	○ _____	○ _____

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

Patient/Guardian Signature _____ Date: _____