

M I R T S C H I N G D . C .
D E W A Y N E M .
DOCTOR OF CHIROPRACTIC

CASE HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original case history up to date, please provide us with the following information.

Patient Name:

Date:

Address:

Home Phone:

City/St/Zip:

Work Phone:

1. List present complaints (describe fully):
2. Duration of present condition:
What do you believe caused this condition?
3. Describe any falls, surgery, and/or accidents since last visit:
4. Date of last physical:
Date of last adjustment:
5. Describe condition(s) for which you were previously treated in this office and your response to the treatment:
6. Since your last visit here, have you consulted another doctor? Yes No
If so, give doctor's name and condition for which you were treated:
7. What type of treatment did you receive?
8. Other information the doctor should know regarding this condition:

Patient's Signature _____ Date _____

Doctor's Comments:

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D O C T O R O F C H I R O P R A C T I C

EXAM QUESTIONNAIRE

Patient Name:

Date:

This questionnaire has been designed to give the doctor information as to how your PAIN has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE BOX which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 - Pain Intensity

Section 2 - Personal Care

Section 3 - Lifting

Section 4 - Walking

Section 5 - Sitting

Section 6 - Standing

Section 7 - Sex Life

Section 8 - Social Life

Section 9 - Sleeping

Section 10-Traveling