Next Level Wellness Center Case History File

Name____Date__________________________

Address ___________________________________ City__________________State_____________Zip______________

Age________ Birth date__________________ Sex_____ Social Security No.__________________________________

Occupation_______________________Employer__________________________Referred by____________________

Telephone (C) _____________________________________ Email____

(H)_____________________________________ **Ok to receive invoice via email?** Yes ☐ No ☐

Ok to receive newsletter via email? Yes ☐ No ☐

CURRENT SYMPTOMS:

HEAD:
___Headache
___Head feels heavy
___Loss of memory
___Tension Headache
___Light-headedness
___Fainting
___Loss of smell/taste
___Ringing in ears
___Loss of balance
___Dizziness
___Loss of hearing
___Pain in ears

NECK:
___Neck pain
___Neck pain w/movement
___Pinched nerve in neck
___Neck feels out of place
___Stiff neck
___Muscle spasms in neck
___Grinding sounds neck
___Popping sounds neck

ARMS & HANDS:
___Pain in upper arm
___Pain in forearm
___Pain in hands/fingers
___Swollen joints in fingers
___ Numb/tingling(arms-fingers)
___ Fingers go to sleep
___ Loss of strength
___Loss of grip

MID-BACK:
___Mid-back pain
___Pain between shoulder
___Muscle spasms

CHEST:
___Chest pain
___Shortness of breath
___Pain around ribs

ABDOMEN:
___Nausea
___Gas
___Constipation
___Diarrhea

LOW BACK:
___Low back pain
___Low back pain is worse:
___Lifting
___Pinched nerve
___Stooping
___Standing
___Sitting
___Bending
___Coughing
___Postural pain
___Slipped disc
___Low back feels out

SHOULDERS:
___Pain in shoulder joints (R-L)
___Muscle Stiffness
___Arthritis (R-L)
___Can't Raise Arm
___Tension in shoulders
___Bursitis (R-L)
___Pinched nerve (R-L)

HIPS, LEG & FEET:
___Pain in buttocks (R-L)
___Pain in hip joint (R-L)
___Pain to knee (R-L)
___Pain down leg (R-L)
___Numbness in legs (R-L)
___Numb feet/toes (R-L)
___Swollen feet (R-L)
___Painful joints-toes (R-L)

WOMEN ONLY:
___Menstrual pain
___Cramping
___Irregularity

GENERAL:
___Depressed
___Fatigue
___Loss of Sleep
___Loss o f Weight

PRIOR CONDITIONS: Please mark (**X**) all conditions that apply:

___Headaches, migraines
___Vision problems, contact lenses
___Hearing problems, deafness
___Injuries to face or head
___Sinus problems
___Dental bridges, braces
___Jaw pain, TMJ problems
___Asthma/ Lung conditions
___Constipation, diarrhea
___Hernia
___Birth control, IUD

___Chronic pain
___Muscle or joint pain
___Muscle, bone injuries
___Numbness or tingling
___Sprains, strains
___Arthritis, tendonitis
___Cancer, tumors
___Spinal column disorders
___Diabetes
___Pregnancy
___Heart, circulatory problems

___Fatigue
___Tension, stress
___Depression
___Sleep difficulties
___Allergies, sensitivity
___Rash, athletes foot
___Infectious disease
___Blood clots
___Varicose veins
___High/Low blood pressure
___G.I. problems

___Other medial conditions not listed. Explain :____

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Are you on currently on any medications? No___ Yes___ If yes, detail:____

Any surgeries or accidents?____

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I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patients Signature ____ Date _____________________