Case History Update

Patient Name: _____ **Date:** _____

**If this is related to a work or auto injury, please see receptionist before continuing!*

Liberty Park Chiropractic

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Complaint #1:	**Complaint #2:**
1)	**2)**
Describe how the symptoms began and date of onset if known for each condition:	
1) **Date:**	**2)** **Date:**
Have you experienced these symptoms before:	
1) □ Never □ On and off □ For Years	**2)** □ Never □ On and off □ For Years
How do you feel your symptoms are changing with time:	
1) □ Improving □ Worsening □ No change	**2)** □ Improving □ Worsening □ No change
What are the qualities of these symptoms:	
1) □ Achy □Burning □Dull □Sharp □Stiff □Throbbing □Tight □Sore □ Other: _____	**2)** □ Achy □Burning □Dull □Sharp □Stiff □Throbbing □Tight □Sore □ Other: _____
On a scale of 1-10 (0=no pain, 10=most severe pain) how would you rate the intensity of your pain today:	
1) 1-10: _____	**2)** 1-10: _____
How often do you experience your symptoms:	
1) □Occasionally □Intermittent □Frequently □Constant	**2)** □Occasionally □Intermittent □Frequently □Constant
What time of the day do your symptoms feel better:	
1) □AM □Mid-Day □PM □None	**2)** □AM □Mid-Day □PM □None
What aggravates your symptoms:	
1)	**2)**
What alleviates your symptoms:	
1)	**2)**
Have you seen another provider for this condition (If so please provide their name and when):	
1)	**2)**

ONLY fill out this section if you are being seen today for **HEADACHES**:

1) Location of headache:

_____

2) Frequency of headache:

_____ x per day/week/month

3) Has it lasted more then 72 hours:

□ Yes □ No

4) Do medications help: □ Yes □ No

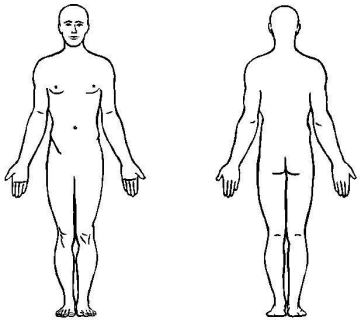
5) If yes, which one's:

_____

6) Do you see an aura or have visual problems due to headache? Explain:

_____

All patients, please mark on the body with an X where you are having symptoms:



ONLY if changed, please update your contact info:

Address: _____

_____

Phone: H / C / W: _____

Email: H /W: _____

Doctor's Notes: