Sonoran Wellness Center
Case History

Today's Date: _____/_____/_____ Case Number: _____

Patient Information

Name: (Last) _____ (First) _____ (MI) ____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (Cell) _____

_____ Birth Date: _____/_____/_____

E-mail: _____

Occupation: _____

Employer: _____

Person to contact in case of emergency _____

Relationship: _____ Phone: (H) _____ (W) _____

Last MD/Health Care check up: _____

Provider and phone number: _____

_____

Current Medications: _____

_____

Over the Counter Drugs: _____

_____

Nutritional Supplements / Vitamins: _____

How did you find out about Sonoran Wellness Center?

○ Advertisement ○ Live Nearby ○ Referral (who?) ○ Other (please list)

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY:

Symptoms

Do you currently have any symptoms? O Yes O No_____

_____

_____

If yes when did this begin? _____
Do you feel that the symptoms are getting progressively worse? O Yes O No O Same
Are these symptoms constant or does it come and go? _____
Is there a time when it is better or worse? _____

Does it interfere with: OSleep O Work O Play O Daily Routine O Quality of Life

Is it painful to: O Sit O Stand O Walk O Bend over O Other _____
Have you seen any other health care professional for the above pain or symptom?
O Yes O No _____
If yes whom?_____
Result _____

Chiropractic

Have you ever received chiropractic spinal adjustments by a Doctor of Chiropractic?
O Yes O No: If yes, when was your last visit? _____
How long were you receiving chiropractic adjustments? _____
What was your frequency or visits?_____
If you stopped care, why did you stop? _____
Were you pleased with the chiropractic care that you received? O Yes O No
Does your immediate family receive chiropractic care? O Yes O No

X-RAY - FEMALE ONLY – PREGNANCY RELEASE

I certify to the best of my knowledge that I AM NOT pregnant, and authorize appropriate diagnostic x-rays. I recognize that if I am pregnant radiation exposure to my abdomen may possibly injure the fetus. I understand that the likelihood of such injury is slight.

_____ Date: _____/_____/_____
Patient Signature (parent or guardian if minor)

Is it possible you are pregnant? OYes ONo Use of IUD Device? OYes ONo

First day of last menstrual period: _____/_____/_____

Have you had a hysterectomy or tubal ligation? OYes ONo Date: _____/_____/_____