JENNIFER SANSEN, D.C.
200 Bethel Road
Port Orchard, WA 98366
(360) 876-4171

CASE HISTORY

Date: ______________________

Name: ____ Social Security #: ______________________________
Address: ________________________________ City ________________ State: ________ Zip: __________
Phone: ( )_______________________ Cell# ( )__________________E-mail address ________________
Age: _____ Birth Date: __________ Marital Status: S M W D How many children: _____ Ages: __________
Occupation: __________________________ Employer: ____
Employer Location (city) _____________________________ Work Phone: (______)________________________
Name of Spouse: ______________________________ Occupation of Spouse: ___________________________
Birth Date of Spouse: ____________ Social Security # of Spouse (for insurance): ______________________
How were you referred to our office? ____
Have you ever received chiropractic care? YES NO If yes, when? _______________________________________

Primary Complaint & Purpose of this Visit: ____
____

How long have you had this complaint? ____

Is this the result of an injury / accident? YES NO If yes, please explain: _________________________________
____

Are the pains (please circle): SHARP DULL CONSTANT INTERMITTENT

Has it interfered with daily activities such as (please circle): WORK HOME EMOTION SLEEP SPORTS

OTHER (please list):____

What makes it worse? ____

What makes it better? ____

Is it worse during certain times of the day? YES NO If yes, when? _______________________________________

Have you had this before? YES NO If yes, when? ____

Is this condition getting progressively worse? ____

List other doctors consulted for these complaints / injuries:

1. Name: ______________________________ When consulted ______________________________

   Treatment: ____________________________ Results: __________________________________

2. Name: ______________________________ When consulted ______________________________

   Treatment: ____________________________ Results: __________________________________

Any home remedies, ice, heat, etc.:____

Other complaints:____

I give my permission for the doctors at Kitsap Chiropractic Clinic to treat a minor child.

Parent / Guardian Signature: ____________________________________ Date: ___________________________

Patient Name: ____ Date: ____

List surgical operations & years: ____

____

Medications: ____

Age of mattress _____ __comfortable __uncomfortable

Sleeping posture: __side __stomach __back

Are you wearing: __heel lifts __sole lifts __inner soles __arch supports

Have you been in an auto accident: __past year __past 5 years __over 5 years __never

Describe: ____

List any hobby / sports injuries: ____

Have you ever had any mental or emotional disorders? __yes __no When? ____

Have others in your family had such disorders? __yes __no When? ____

FAMILY HEALTH INFORMATION: (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health. Please include conditions such as heart disease, arthritis, cancer, diabetes, etc.).

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	**YES**	**NO**	**DESCRIBE**
Been knocked unconscious?	☐	☐	
Been treated for a spine or nerve disorder	☐	☐	
Had a fractured bone	☐	☐	
Been hospitalized other than surgery	☐	☐	
DO YOU:	**YES**	**NO**	**DESCRIBE**
Now take vitamins or minerals	☐	☐	
Think you may need vitamins/minerals	☐	☐	

DATE OF LAST:	**0-6 months**	**6-18 mo.**	**over 18 mo.**	**never**
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	**HEAVY**	**MOD.**	**LIGHT**	**NONE**
Alcohol	☐	☐	☐	☐
Coffee/Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Physical stress	☐	☐	☐	☐
Mental stress	☐	☐	☐	☐

List all conditions for which you have been treated in the last 10 years.

____

____

____

____

____

____

IN CASE OF EMERGENCY: (Name of relative or close friend):

Address: ____ Phone: ____

Name: ____

Address: ____ Phone: ____