



2136 Yale St. Suite B Houston, TX 77008 832.668.5974 www.wellnessheights.com
mydrnicci@gmail.com

Dr. Nicole Sletten, D.C. and/or Dr. Bret Buffalohead, D.C.

Chiropractic Case History

Name Sex M F Married Single Divorced Date

Address City State Zip

H. Phone W. Phone Date of birth Age

Referred by Social Security #

Occupation Employer

Have you ever received chiropractic care? Yes No If yes, when?

1. Chief Complaint

Location of Complaint:

Complaint Began when and how?

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?

Do you have any numbness or tingling in your body? Where?

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain/ complaint imaginable)

How frequent is complaint present, how long does it last?

Does anything aggravate the complaint?

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

3. Past Health History:

A. Previous illness you've had in your life:

B. Previous injury or trauma, broken bones? When?

C. Allergies:

D. Medications: Reason for taking:

E. Surgeries: When? Type of Surgery:

F. Females/ Pregnancies and outcomes: Outcome:

Pregnancies/ Dates of delivery:

What was the date of the beginning of your last day of your menstrual period?

4. Family Health History:

Associated health problems of relatives:

Deaths in immediate family:

Cause of parents or siblings death: Age of death:

5. Social and Occupational History:

A. Level of Education:

B. Job description:

C. Recreational activities:

D. Do you smoke, drink, or take coffee? How long/ how much per day?

What is your goal seeking chiropractic care?