Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____ Home Phone _____

Address _____ City _____ State _____ Zip _____ Work Phone _____

Date of Birth _____ Age _____ M ___ F ___ Marital Status _____ No. Children _____

Occupation _____ SS # _____ Spouse _____

Who Is Responsible For The Account? _____ Referred By _____

Please Check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O - Occasional F - Frequent C - Constant

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neruralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tailbone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen Joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE & THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsilitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of Arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low bood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose Veins
			GENITO-URINARY
☐	☐	☐	Bed wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal Symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS IF YOU HAVE HAD:

☐ Allergy	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐	Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐	Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐	Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐	Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐	Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐	Venereal Disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐	Whooping cough

Have you had previous chiropractic care?_____ If yes, date of last care _____

Do you have Health and Accident Insurance?_____ If yes, with what company? _____

Is this an Industrial Accident Case? Yes ☐ No ☐

Please Print

What is your major complaint? _____

_____

Other complaints _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggrivate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine Other _____

_____

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for present condition_____

_____

What do you believe is wrong with you? _____

List surgical operations and years _____

_____

Drugs you now take: ☐ Nerve Pills ☐ Pain killers ☐ Muscle Relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth Control

Others _____

Dental Visits: ☐ Every six months ☐ Yearly ☐ Toothache or emergency only ☐ Complete dentures

Age of Mattress _____ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe _____

Have you ever had any mental or emotinal 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 picture.)*

Name	Relation	Past and Present Health Problems

HAVE YOU EVER:	**YES**	**NO**	**DESCRIBE BRIEFLY**
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fractured bone?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	

DO YOU:	**YES**	**NO**	**DESCRIBE BRIEFLY**
Now take vitamins or minerals?	☐	☐	
Think you may need vitamins or minerals?	☐	☐	
Have an allergy to any drug?	☐	☐	

DATE OF LAST:	**Less than 6 months**	**6 - 18 Months**	**Over 18 Months**	**Never**
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME _____

ADDRESS _____ PHONE _____