# 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 _____ FAX # _____

OCCUPATION _____ SS# _____ SPOUSE _____ E-MAIL _____

WHO IS RESPONSIBLE FOR THIS 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
- ☐☐☐ Neuralgia
- ☐☐☐ 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 tail bone
- ☐☐☐ 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
- ☐☐☐ Tonsillitis

**O F C**

**CARDIO-VASCULAR**
- ☐☐☐ Hardening of arteries
- ☐☐☐ High blood pressure
- ☐☐☐ Low blood 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 YOU HAVE OR HAVE HAD:

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

Have you ever 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



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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 aggravate 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 pills
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 ❑ More than five years ❑ Never
Describe _____

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 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 | ❑ | ❑ | ❑ | ❑ |

| 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 _____