

# 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:

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

**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 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 ☐ Over 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? ☐ YES ☐ NO

Used a cane, crutch, or other support? ☐ YES ☐ NO

Been treated for a spine or nerve disorder? ☐ YES ☐ NO

Had a fractured bone? ☐ YES ☐ NO

Been hospitalized for other than surgery? ☐ YES ☐ NO

**DO YOU:**

Now take vitamins or minerals? ☐ YES ☐ NO

Think you may need vitamins or minerals? ☐ YES ☐ NO

Have an allergy to any drug? ☐ YES ☐ NO

**DATE OF LAST:**

Less than 6 months

6-18 months

Over 18 months

Never

Spinal examination ☐ Less than 6 months ☐ 6-18 months ☐ Over 18 months ☐ Never

Physical examination ☐ Less than 6 months ☐ 6-18 months ☐ Over 18 months ☐ Never

Blood test ☐ Less than 6 months ☐ 6-18 months ☐ Over 18 months ☐ Never

Chest X-ray ☐ Less than 6 months ☐ 6-18 months ☐ Over 18 months ☐ Never

Spinal X-ray ☐ Less than 6 months ☐ 6-18 months ☐ Over 18 months ☐ Never

Dental X-ray ☐ Less than 6 months ☐ 6-18 months ☐ Over 18 months ☐ Never

Urine test ☐ Less than 6 months ☐ 6-18 months ☐ Over 18 months ☐ Never

**HABITS**

Heavy

Moderate

Light

None

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

Alcohol ☐ Heavy ☐ Moderate ☐ Light ☐ None

Coffee ☐ Heavy ☐ Moderate ☐ Light ☐ None

Tobacco ☐ Heavy ☐ Moderate ☐ Light ☐ None

Drugs ☐ Heavy ☐ Moderate ☐ Light ☐ None

Exercise ☐ Heavy ☐ Moderate ☐ Light ☐ None

Sleep ☐ Heavy ☐ Moderate ☐ Light ☐ None

Appetite ☐ Heavy ☐ Moderate ☐ Light ☐ None

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

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_