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: ____/____/____ F ____ M ____ Marital Status: _____ Cellular Phone:_____

S.S.N.: _____E-mail Address:_____ No. of Children: _____

Name of General Practitioner:_____ G.P.'s Office No.: _____

Who is responsible for this account?_____How did you hear about us? _____

Internet/Web Site: Friend/Relative Referral: Dr. Referral:

Please check the appropriate box for any of the following symptoms that 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
☐☐☐ Fainting
☐☐☐ Headache
☐☐☐ Loss of sleep
☐☐☐ Loss of weight

MUSCLE & JOINT

☐☐☐ Arthritis
☐☐☐ Bursitis
☐☐☐ Low back pain
☐☐☐ Neck pain or stiffness
☐☐☐ Pain Between shoulders

Pain or numbness in:

☐☐☐ Shoulders
☐☐☐ Arms
☐☐☐ Elbows
☐☐☐ Hands
☐☐☐ Hips
☐☐☐ Legs
☐☐☐ Knees
☐☐☐ Feet
☐☐☐ Poor posture
☐☐☐ Sciatica
☐☐☐ Spinal Curvature
☐☐☐ Swollen Joints

O F C

GASTRO-INTESTINAL

☐☐☐ Constipation
☐☐☐ Diarrhea
☐☐☐ Difficult digestion

CARDIO-VASCULAR

☐☐☐ High blood pressure
☐☐☐ Low blood pressure

RESPIRATORY

☐☐☐ Chest pain

WOMEN ONLY

☐☐☐ Excessive menstrual flow
☐☐☐ Irregular cycle
☐☐☐ Painful menstruation
☐☐☐ Cramps or backache
k☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism ☐ Cancer ☐ Gout ☐ Multiple Sclerosis
☐ Arthritis ☐ Diabetes ☐ Heart Condition ☐ Stroke

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

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? _____

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 felt really 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 relaxant ☐ "Pep" pills ☐ Tranquilizers

☐ Birth control pills ☐ Others: _____

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:	**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?	☐	☐	

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	☐	☐	☐	☐

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

NAME: _____

ADDRESS: _____ PHONE: _____