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 _____

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 HAD:

☐ Alcoholism	☐ 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

PLEASE PRINT

What is your major complaint? _____

_____

List surgical operation and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers
☐ "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 had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

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 anything other than surgery?	☐	☐	_____
DO YOU:			
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	☐	☐	☐	☐

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

NAME _____

ADDRESS: _____ PHONE: _____