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 satisfactory, 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
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of Sleep
- ☐ ☐ ☐ Loss of Weight
- ☐ ☐ ☐ Nervousness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

MUSCLE & JOINT

- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low Back Pain
- ☐ ☐ ☐ Neck Pain/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/Gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon Trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult Digesting
- ☐ ☐ ☐ Excessive Hunger
- ☐ ☐ ☐ Gall Bladder Trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver Trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over Stomach
- ☐ ☐ ☐ Poor Appetite
- ☐ ☐ ☐ Vomiting

EYES, EARS, NOSE, & THROAT

- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear Infections
- ☐ ☐ ☐ Ringing in ears
- ☐ ☐ ☐ Enlarged Glands
- ☐ ☐ ☐ Enlarged Thyroid
- ☐ ☐ ☐ Eye Pain
- ☐ ☐ ☐ Failing Vision
- ☐ ☐ ☐ Gum Trouble
- ☐ ☐ ☐ Nasal Obstruction
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus Infections
- ☐ ☐ ☐ Sore Throat
- ☐ ☐ ☐ Tonsillitis

O F C

CARDIOVASCULAR

- ☐ ☐ ☐ 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
- ☐ ☐ ☐ Wheezing

SKIN

- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergies
- ☐ ☐ ☐ Itching

GENITO-URINARY

- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in Urine
- ☐ ☐ ☐ Frequent Urination
- ☐ ☐ ☐ Loss of Kidney Control
- ☐ ☐ ☐ Kidney Stones
- ☐ ☐ ☐ Painful Urination
- ☐ ☐ ☐ Prostate trouble

WOMEN ONLY

- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excessive Menstrual flow
- ☐ ☐ ☐ Irregular cycles

☐ 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	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Rheumatic Fever	☐ Venereal Diseases

PLEASE PRINT

List any medications that you are taking: ____

____

Age of mattress: _____ yrs. ☐ Firm ☐ Soft ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch Supports

Have you ever had any mental or emotional disorders: ☐ No ☐ Yes When________________________

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

DO YOU:			
Now take vitamins or minerals?	☐	☐	____________________
Think you may need vitamins or minerals?	☐	☐	____________________
Have an allergy to any drugs?	☐	☐	____________________

DATES OF LAST:	**Within 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	☐	☐	☐	☐
Illegal Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

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

NAME:____ PHONE:_____________________

ADDRESS:____