Confidential Patient Case History

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home phone _____ Work Phone_____ Cell Phone_____ FAX#_____

Date of birth____/__/____ M ☐ F ☐ Marital Status_____ No. Children_____

Occupation_____ 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 need all of the facts about your health. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – Occasional
F – Frequent
C – Constant

GENERAL

O	F	C	
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/Depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

MUSCLE & JOINT

O	F	C	
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders

Pain or numbness in:

O	F	C	
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet

O	F	C	
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

GASTRO-INTESTINAL

O	F	C	
☐	☐	☐	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 for blood

EYES, EARS, NOSE & THROAT

O	F	C	
☐	☐	☐	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

CARDIO-VASCULAR

O	F	C	
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heartbeat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles

RESPIRATORY

O	F	C	
☐	☐	☐	Chest pain
☐	☐	☐	Chronic pain
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

SKIN

O	F	C	
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

GENITO-URINARY

O	F	C	
☐	☐	☐	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

O	F	C	
☐	☐	☐	Pain in breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

Are you pregnant? ☐ Yes ☐ No

Check the following conditions that you have had:

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

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 this 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 ☐ Antidepressants ☐ Tranquilizers

☐ Birth control pills Others_____

Dental visits: ☐ Every six months ☐ Yearly ☐ Toothache or emergency only ☐ Complete dentures

Age of mattress:_____ ☐ Comfortable ☐ Uncomfortable

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: providing information about your family members will give us a better view into 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 other than for 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	☐	☐	☐	☐

LIST BELOW ALL CONDITONS FOR WHICH YOU HAVE BEEN TREATED FOR IN THE PAST 10 YEARS

_____

_____

_____

_____

_____

_____

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

Name_____Phone_____

Address_____