

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 Code: _____ Work Phone: _____

Date of birth: ____ / ____ / ____ F ____ M ____ Marital Status: _____ No. of Children: _____

Who is responsible for this account? _____ Referred by: _____ Occupation: _____

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
- 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
- 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? 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

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: _____