CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic therapy can help you. If we do not believe your condition may respond satisfactorily, we will not accept your case. THANK YOU.

NAME____ DATE___________ SS#______________ HOME #____________________

ADDRESS___________________________ CITY________________ STATE_______ ZIP__________ WORK #____________________

DATE OF BIRTH_____________________ AGE_________ M____ F_____ MARRIED: Y / N CELL #_____________________

OCCUPATION_______________________ EMPLOYER ________________________EMAIL:_____________________________

PERSON RESPONSIBLE FOR ACCOUNT?_____________________ SPOUSE_____________ REFERRED BY_____________________

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

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot Trouble
☐ ☐ ☐ Low Back Pain or Stiffness
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Painful Tailbone
☐ ☐ ☐ Upper Back Pain
☐ ☐ ☐ Neck Pain or Stiffness
☐ ☐ ☐ Poor Posture
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen Joints

O F C

MUSCLE & JOINT

Pain or numbness in:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Upper Arm
☐ ☐ ☐ Forearms
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet

OTHER

☐ ☐ ☐ Losing Weight
☐ ☐ ☐ High Cholesterol
☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Painful Menstruation (Women Only)
☐ Yes ☐ No Are you pregnant?

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fever
☐ ☐ ☐ Loss of Sleep
☐ ☐ ☐ Constipation
☐ ☐ ☐ Asthma
☐ ☐ ☐ Earache
☐ ☐ ☐ Sinus Infection
☐ ☐ ☐ Bed Wetting
☐ ☐ ☐ Painful Urination
☐ ☐ ☐ Headaches

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

☐ Alcoholism ☐ Cancer ☐ Epilepsy ☐ Heart Disease ☐ Stroke
☐ Appendicitis ☐ Diabetes ☐ Gout ☐ Miscarriage ☐ HIV/Aids

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses; thus, information about your family members will give us a better idea of your total health picture.

Family Member (mother, grandfather etc.)	**Cancer**	**Stroke**	**Heart Dis.**	**Diabetes**	**Spinal Conditions**

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):
NAME____ RELATION_________________ PHONE____________________________
ADDRESS____ CITY_______________________ STATE_______ ZIP___________

Have you ever had previous chiropractic care? ☐ Yes ☐ No If yes, date of last care and name of doctor_____________________________
Do you have Health or Accident Insurance? ☐ Yes ☐ No If yes, with what company?____

CHIEF COMPLAINT

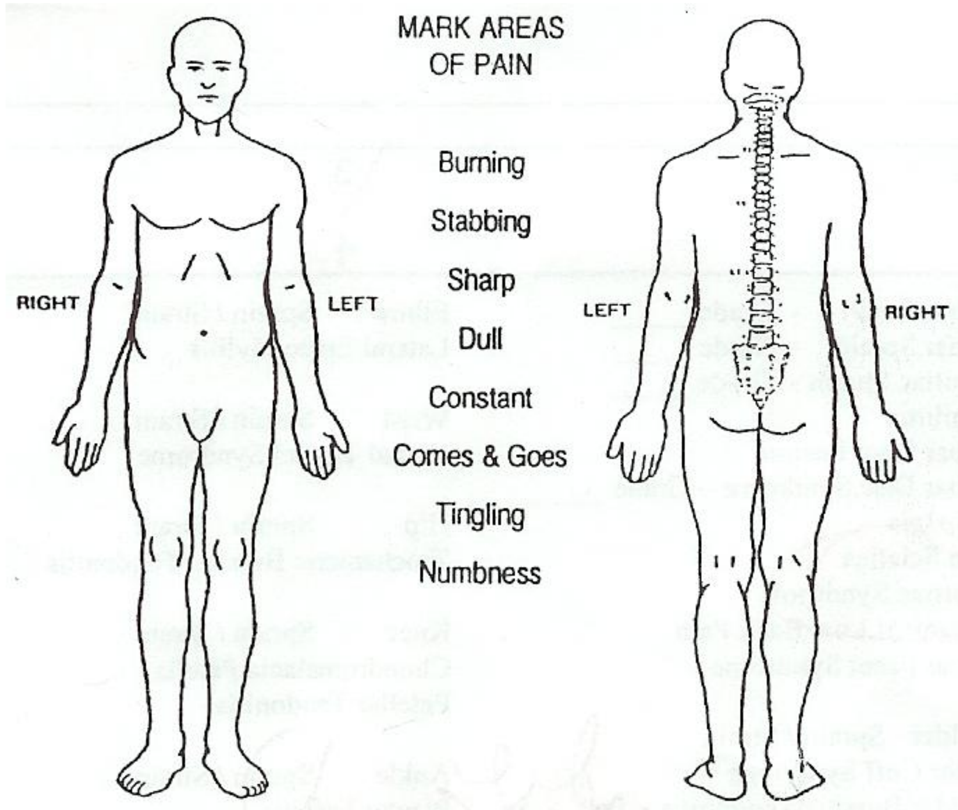
What is your major complaint?____________________ When did this begin?__________
Second complaint____________________ When did this begin?__________
Third complaint____________________ When did this begin?__________
Fourth complaint____________________ When did this begin?__________

Is this condition (your major complaint) getting progressively ☐ Better, ☐ Worse, ☐ Staying the same Is it: ☐ Constant ☐ Intermittent
Have you had this or similar conditions in the past? ☐ Yes ☐ No When?__________ Describe____________________
What improves your condition? ☐Rest ☐Ice ☐Heat ☐Medications ☐Lying down ☐Standing ☐Sitting ☐Walking ☐Other__________
What aggravates your condition? ☐Lying ☐Standing ☐Sitting ☐Walking ☐Running ☐Exercising ☐Coughing ☐Other__________
How would you describe the pain? ☐Sharp ☐Stabbing ☐Dull ☐Achy ☐Burning ☐Throbbing ☐Tingling ☐Numbing ☐Other__________
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 had for this/these conditions____________________
____
What caused your pain/condition to develop?____________________
List surgical operations and years:____________________
____
Drugs you now take: ☐ Pain Killers ☐ Anti-inflammatory ☐ Muscle Relaxants ☐ Blood Pressure ☐ Cholesterol ☐ Birth Control ☐Anti-depressants Other:____________________
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?____________________

NAME OF YOUR MEDICAL DOCTOR____________________ PHONE NUMBER__________
ADDRESS____________________ CITY__________ STATE__________ ZIP__________

MAY WE SEND A REPORT OF YOUR TREATMENT TO YOUR DOCTORS and/or THERAPISTS? ☐ Yes ☐ No



Date:__________ Signature:____________________
(Parent or legal guardian if a minor)