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

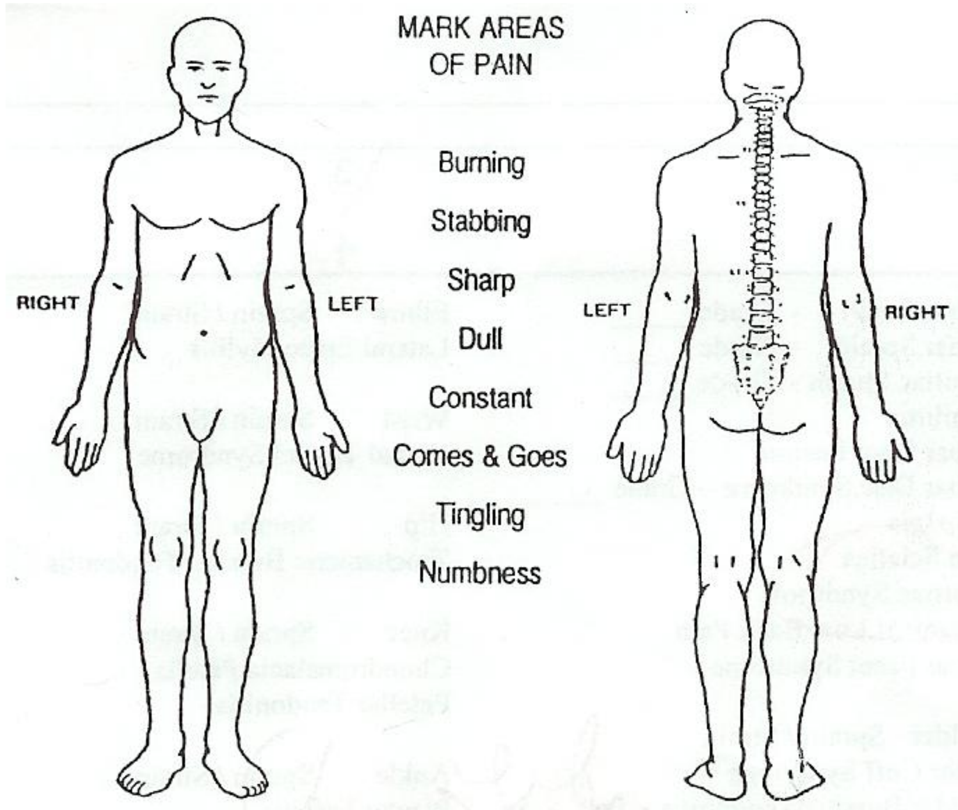
What is your major complaint?__________ When did this begin?______
Second complaint__________ When did this begin?______
Third complaint__________ When did this begin?______
Fourth complaint__________ When did this begin?______

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)