

Confidential Patient Case History

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



Name: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell: _____ Work: _____
 Date of Birth: _____ Age: _____ M _____ F _____ Marital Status: _____ # Of Children _____
 Occupation: _____ SS# _____ Spouse's Name: _____
 Email: _____ Referred By: _____
 Primary Care Physician: _____ Phone #/Address: _____

Please circle the appropriate response 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-OCASSIONAL
 F-FREQUENT
 C-CONSTANT

O F C

GENERAL

- O F C ALLERGY
- O F C CHILLS
- O F C CONVULSIONS
- O F C DIZZINESS
- O F C FAINTING
- O F C FATIGUE
- O F C FEVER
- O F C HEADACHE
- O F C LOSS OF WEIGHT
- O F C NERVOUSNESS/DEPRESSION
- O F C NEURALGIA
- O F C NUMBNESS
- O F C SWEATS
- O F C TREMORS

MUSCLE & JOINT

- O F C ARTHRITIS
- O F C BURSITIS
- O F C FOOT TROUBLE
- O F C HERNIA
- O F C LOW BACK PAIN
- O F C LUMBAGO
- O F C NECK PAIN OR STIFFNESS
- O F C PAIN BETWEEN SHOULDERS

PAIN OR NUMBNESS IN:

- O F C ARMS
- O F C ELBOWS
- O F C HANDS
- O F C HIPS
- O F C LEGS
- O F C KNEES
- O F C FEET
- O F C PAINFUL TAILBONE
- O F C SPINAL CURVITURE
- O F C SWOLLEN JOINTS

O F C

GASTRO-INTESTINAL

- O F C BELCHING OR GAS
- O F C COLITIS
- O F C COLON TROUBLE
- O F C CONSTIPATION
- O F C DIARRHEA
- O F C DIFFICULTY DIGESTION
- O F C DISTENSION OF ABDOMEN
- O F C EXCESSIVE HUNGER
- O F C GALL BLADDER TROUBLE
- O F C HEMORRHOIDS
- O F C INTESTINAL WORMS
- O F C JAUNDICE
- O F C LIVER TROUBLE
- O F C NAUSEA
- O F C POOR APPETITE
- O F C VOMITING
- O F C VOMITING OF BLOOD

EYES, EARS

NOSE & THROAT

- O F C ASTHMA
- O F C COLDS
- O F C CROSSED EYES
- O F C DEAFNESS
- O F C DENTAL DECAY
- O F C EARACHE
- O F C EAR DISCHARGE
- O F C EAR NOISES
- O F C ENLARGED GLANDS
- O F C ENLARGED THYROID
- O F C FAILING VISION
- O F C FAR SIGHTEDNESS
- O F C GUM TROUBLE
- O F C HAY FEVER
- O F C HOARSENESS
- O F C NASAL OBSTRUCTION
- O F C NEAR SIGHTEDNESS
- O F C NOSEBLEEDS
- O F C SINUS INFECTION

O F C

CARDIO- VASCULAR

- O F C HARDENING OF ARTERIES
- O F C HIGH BLOOD PRESSURE
- O F C LOW BLOOD PRESSURE
- O F C PAIN OVER HEART
- O F C POOR CIRCULATION
- O F C RAPID HEART BEAT
- O F C SLOW HEART BEAT
- O F C SWELLING OF ANKLES

RESPIRATORY

- O F C CHEST PAIN
- O F C CHRONIC COUGH
- O F C DIFFICULTY BREATHING
- O F C SPITTING UP BLOOD
- O F C SPITTING UP PHLEGM

SKIN

- O F C BOILS
- O F C BRUISE EASILY
- O F C DRYNESS
- O F C HIVES OR ALLERGY
- O F C ITCHING
- O F C SKIN ERRUPTIONS (RASH)
- O F C VARICOSE VEINS

GENITO-URINARY

- O F C BED-WETTING
- O F C BLOOD IN URINE
- O F C FREQUENT URINATION
- O F C INABILITY TO CONTROL KIDNEYS
- O F C KIDNEY INFECTION OR STONES
- O F C PAINFUL URINATION
- O F C PUS IN URINE

FOR WOMEN ONLY

- O F C CONGESTED BREASTS
 - O F C CRAMPS OR BACKAHES
 - O F C EXCESSIVE MENSTRUAL FLOW
 - O F C HOT FLASHES
 - O F C IRREGULAR CYCLE
 - O F C MENOPAUSAL SYMPTOMS
- 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 | — PLEURISY | — TYPHOID FEVER |
| — ARTHRITIS | — EMPHYSEMA | — LUMBAGO | — PNEUMONIA | — ULCERS |
| — CANCER | — EPILEPSY | — MALARIA | — POLIO | — VENEREAL DISEASE |
| — CHOREA | — FEVER BLISTERS | — MEASLES | — RHEUMATIC FEVER | — WHOOPING COUGH |

HAVE YOU EVER HAD 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 ___