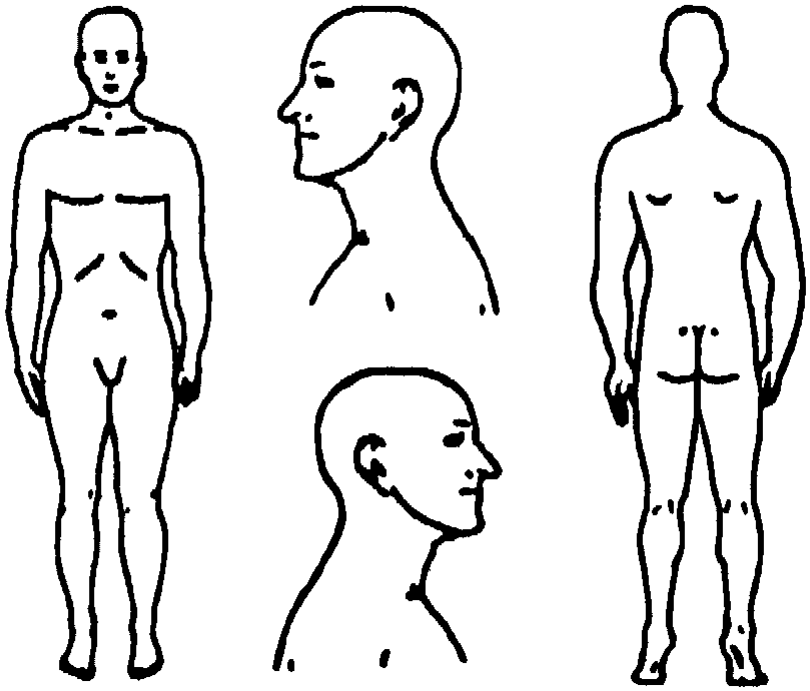
CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: Please complete both sides of this questionnaire. Your answers will help us determine how chiropractic can help you.

NAME: _____ HOME PHONE: _____
CELL: _____ WORK: _____ E-MAIL: _____
ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____
DATE OF BIRTH: _____AGE:___ M __ F __ MARITAL STATUS: _____ SPOUSE NAME: _____
OCCUPATION: _____ EMPLOYER_____REFERRED BY: _____
WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ TODAY'S DATE: _____

How long have you had your symptoms? _____days _____weeks _____months _____years
On the diagram below, please indicate where, and what type of symptoms you are experiencing right now. Write the appropriate abbreviations (see the key below) over the area of the body where those symptoms are occurring.

A= ACHE
B= BURNING
N= NUMBNESS
P= PINS & NEEDLES
S= STABBING
O= OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN
0 1 2 3 4 5 6 7 8 9 10

Please check the appropriate box for any of the following symptoms, which you now have or have had previously. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL = O **(Check one)**
FREQUENT = F
CONSTANT = C

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

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot Trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low Back Pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck Pain or Stiffness
☐ ☐ ☐ Jaw Pain
☐ ☐ ☐ Pain between Shoulders

Pain or Numbness In:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet

☐ ☐ ☐ 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 Of Blood

EYES, EARS, NOSE, & THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed Eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear Discharge
☐ ☐ ☐ Ear Noise
☐ ☐ ☐ 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 The Arteries
☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Low Blood Pressure
☐ ☐ ☐ Pain over Heart
☐ ☐ ☐ Poor Circulation
☐ ☐ ☐ Rapid Heart Beat
☐ ☐ ☐ Slow Heart Beat
☐ ☐ ☐ Swelling of Ankles

RESPIRATORY

☐ ☐ ☐ Chest Pain
☐ ☐ ☐ Chronic Cough
☐ ☐ ☐ Difficult Breathing
☐ ☐ ☐ Spitting Up Blood
☐ ☐ ☐ Spitting Up Phlegm
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise Easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or Allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin Eruptions (rash)
☐ ☐ ☐ Varicose Veins

GENITO-URINARY

☐ ☐ ☐ 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

☐ ☐ ☐ Cramps or Backache
☐ ☐ ☐ Irregular Cycle
☐ ☐ ☐ Swollen Breasts
☐ ☐ ☐ Lumps in Breast
☐ Yes ☐ No: Are You Pregnant?

CHECK ALL 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

PLEASE LIST YOUR HIGHEST PRIORITY HEALTH GOALS 1_____2_____3_____

HAVE YOU EVER HAD CHIROPRACTIC CARE? _____IF YES, DATE OF CARE_____

DO YOU HAVE HEALTH AND ACCIDENT INSURANCE? _____IF YES, WITH WHAT COMPANY? _____

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 Your 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? _____
What Do You Believe Is Wrong With You? _____
List Surgical Operations and Years: _____
_____
Are you taking medication? _____ If yes, please list names and dosage_____
_____
Dental Visits: ☐ Every Six Months ☐ Yearly ☐ Toothache or "Emergency" Only ☐ Complete Dentures
Age Of Mattress: _____ ☐ Comfortable ☐ Uncomfortable — Do You Have A Bed Board? _____
Are You Wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports
Have You Been In An Automobile Accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never
Describe:_____
Have You Had Any Other Personal Injury Or Accident? (Broken Bones, Sit Down Falls, Head Injuries -Think back to your childhood)
☐ Past Year ☐ Past 5 Years ☐ Over 5 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; Thus Information About Your Family Members Will Give Us A Better Understanding Of Your Total Health Picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:		Describe Briefly
Been Knocked Unconscious?	☐ Yes ☐ No	_____
Used A Cane, Crutch, Or Other Support?	☐ Yes ☐ No	_____
Been Treated For a Spine Or Nervous Disorder?	☐ Yes ☐ No	_____
Had A Fractured Bone?	☐ Yes ☐ No	_____
Been Hospitalized For Other Than Surgery?	☐ Yes ☐ No	_____
DO YOU:		
Now Take Vitamins, Minerals, or Supplements?	☐ Yes ☐ No	_____
Think You May Need Vitamins, Minerals or Supplements?	☐ Yes ☐ No	_____
Have Any Allergies (to foods, drugs, seasonal, etc)?	☐ 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	☐	☐	☐	☐

PLEASE LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS.
_____
_____
_____
_____
_____
_____
_____
_____

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:_____ **Relation:** _____
Address: _____ **Phone Number:** _____
I Authorize this information to be given to my insurance company_____