# CONFIDENTIAL PATIENT CASE HISTORY

*(PLEASE PRINT)*

DATE _____

NAME _____ ☐ FEMALE ☐ MALE AGE _____

Address Street City St Zip

PHONES: CELL _____ HOME _____ WORK _____ EMAIL _____

WHOM SHOULD WE THANK FOR REFERRING YOU TO US? _____ DATE BIRTH _____

WHAT IS YOUR JOB OR CAREER? _____ SOC SEC # _____

WHAT DO YOU LOVE TO DO? FAVORITE HOBBIES OR PASTIMES? _____

***WHAT IS YOUR CHIEF HEALTH COMPLAINT?*** _____

HOW LONG HAVE YOU HAD IT? _____ HOW IS IT AFFECTING YOUR LIFE? _____

IS IT INTERFERING WITH YOUR? ☐ WORK ☐ HOBBIES ☐ SLEEP ☐ DAILY ACTIVITIES ☐ OTHER ACTIVITIES _____

IS IT GETTING? ☐ BETTER ☐ STAYING THE SAME ☐ WORSE HOW LONG HAS IT BEEN SINCE YOU HAVE FELT REALLY GOOD? _____

HAVE YOU SEEN OTHER DOCTORS FOR THIS? ☐ YES ☐ NO WHAT DIAGNOSIS WERE YOU GIVEN? _____

WHAT TREATMENTS HAVE YOU RECEIVED? _____

WHAT DO YOU BELIEVE IS WRONG WITH YOU? _____

***OTHER COMPLAINTS*** _____

*Have you been in an auto accident or some type of collision?* ☐ No ☐ Yes ☐ Recently ☐ Over 1 year ago ☐ Over 5 years ago

Describe Injuries _____

*Have you had an on-the-job injury?* ☐ No ☐ Yes ☐ Recently ☐ Past _____

*Have you had previous spinal, physical therapy or* chiropractic treatment? ☐ No ☐ Yes _____

*Do you have recent X-Rays, MRI's or other images of your problem area(s)?* ☐ No ☐ Yes _____

Drugs you now take: ☐ Anti-Inflammatories ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-Depressants ☐ Tranquilizers ☐ Birth Control Pills

| Medication | Condition You Take It For | Medication | Condition You Take It For |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*Do you take Supplements, Vitamins or Minerals?* ☐ Yes ☐ No Multiple? ☐ Yes ☐ No Anti Oxidants? ☐ Yes ☐ No

Other Nutrients You Take _____

Would you like help with your supplements and vitamins? ☐ Yes ☐ No Are you allergic to any drug? ☐ Yes ☐ No

Do you exercise: ☐ 0-2 hours per week ☐ 3-5 hours per week ☐ 5 or more hours per week Which drug? _____

Are you? ☐ Content with your weight ☐ *Need to lose* _____ *Pounds* ☐ Need to gain

List surgical operations and years _____

| *HAVE YOU EVER:* | No | Yes | *DESCRIBE BRIEFLY* |
|---|---|---|---|
| Been knocked unconscious? | ☐ | ☐ | |
| Been treated for a spine or nerve disorder? | ☐ | ☐ | |
| Fractured a bone? | ☐ | ☐ | |
| Had an orthopedic (or neuro) surgery or orthopedic treatment? | ☐ | ☐ | |
| Been hospitalized? | ☐ | ☐ | |

| *HABITS* | *Heavy* | *Moderate* | *Light* | *None* |
|---|---|---|---|---|
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Coffee/Caffeine | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Sugar/Carb Binging | ☐ | ☐ | ☐ | ☐ |
| Drugs | ☐ | ☐ | ☐ | ☐ |

***Contact in Case of Emergency:***

NAME _____

ADDRESS _____

PHONE _____

DO YOU HAVE INSURANCE THAT MAY PAY FOR CHIROPRACTIC? ☐ YES ☐ NO CO. NAME _____

*Conditions for which you have been treated in the past 10 years*

| |
|---|
| |
| |
| |
| |

***FAMILY HEALTH*** **Many health problems have family connections**

| NAME | RELATION | PAST AND PRESENT HEALTH PROBLEMS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***PLEASE CHECK THE APPROPRIATE BOX FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR PREVIOUSLY HAD:***
**If a line below does not apply to you, don't mark any box for that line. Just mark a box if a line does apply to you.**

**O = OCCASIONAL F = FREQUENT C = CONSTANT** ***Note that the boxes are marked "O", "F" and "C".***

### O F C *SPINE, ARMS AND LEGS*

- ☐☐☐ Neck Pain or Stiffness
- ☐☐☐ Pain Between Shoulders
- ☐☐☐ Low Back Pain
- ☐☐☐ Sciatica (Pain Into the Leg)

**PAIN OR NUMBNESS IN:**

- ☐☐☐ Shoulders
- ☐☐☐ Arms
- ☐☐☐ Hands
- ☐☐☐ Wrists/Carpal Tunnel
- ☐☐☐ Hips
- ☐☐☐ Legs
- ☐☐☐ Knees
- ☐☐☐ Feet

### O F C *JOINT AND BONE*

- ☐☐☐ Arthritis/Joint Degeneration
- ☐☐☐ Rheumatoid Arthritis
- ☐☐☐ Rheumatic Fever
- ☐☐☐ Bursitis
- ☐☐☐ Gout
- ☐☐☐ Muscle Spasms
- ☐☐☐ Swollen Joints
- ☐☐☐ Hernia
- ☐☐☐ Tail Bone Pain
- ☐☐☐ Poor Posture
- ☐☐☐ Spinal Curvature/Scoliosis
- ☐☐☐ Osteoporosis/Weak Bones
- ☐☐☐ Polio
- ☐☐☐ Multiple Sclerosis

### O F C *ADRENAL & BLOOD SUGAR*

- ☐☐☐ Fatigue
- ☐☐☐ Headache or Migraine
- ☐☐☐ Dizziness
- ☐☐☐ Hypoglycemia
- ☐☐☐ Diabetes
- ☐☐☐ Fainting
- ☐☐☐ Nervousness
- ☐☐☐ Depression
- ☐☐☐ Allergies, Rashes or Hives
- ☐☐☐ Inflammatory/Multiple Pain Areas
- ☐☐☐ Sleep Problems

### O F C *GENERAL*

- ☐☐☐ Thyroid Problems
- ☐☐☐ Goiter
- ☐☐☐ Other Glandular Problems
- ☐☐☐ Chills
- ☐☐☐ Sweats
- ☐☐☐ Fever
- ☐☐☐ Weight Loss
- ☐☐☐ Convulsions/Epilepsy
- ☐☐☐ Tremors
- ☐☐☐ Alcoholism
- ☐☐☐ Anemia

### O F C *GASTRO-INTESTINAL*

- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Gas, Burping
- ☐☐☐ Colitis/Krohns
- ☐☐☐ Colon/Large Intestine Touble
- ☐☐☐ Difficult Digestion
- ☐☐☐ Burning/Acid Stomach
- ☐☐☐ Reflux Disease
- ☐☐☐ Hiatal Hernia
- ☐☐☐ Pain Over Stomach
- ☐☐☐ Ulcers
- ☐☐☐ Distension of Abdomen
- ☐☐☐ Discomfort After Eating
- ☐☐☐ Excessive Hunger
- ☐☐☐ Gall Bladder Trouble
- ☐☐☐ Hemorrhoids
- ☐☐☐ Parasites
- ☐☐☐ Liver Disease
- ☐☐☐ Nausea
- ☐☐☐ Loss of Appetite
- ☐☐☐ Vomiting
- ☐☐☐ Appendicitis
- ☐☐☐ Dysentery
- ☐☐☐ Other Digestive Problem

### O F C *EYES, EARS, NOSE & THROAT*

- ☐☐☐ Colds
- ☐☐☐ Deafness
- ☐☐☐ Ear Ache
- ☐☐☐ Ear Infections
- ☐☐☐ Ear Noises/Tinnitus
- ☐☐☐ Eye Pain
- ☐☐☐ Loss of Vision
- ☐☐☐ Crossed Eyes/Focusing Disorder
- ☐☐☐ Dental Decay
- ☐☐☐ Gum Disease
- ☐☐☐ Hay Fever
- ☐☐☐ Hoarseness
- ☐☐☐ Aggravated Vocal Cords
- ☐☐☐ Nasal Obstruction
- ☐☐☐ Nosebleeds
- ☐☐☐ Sinus Infections
- ☐☐☐ Sore Throat
- ☐☐☐ Tonsillitis
- ☐☐☐ Pain or Difficulty Swallowing

### O F C *IMMUNE*

- ☐☐☐ Weak Immune System
- ☐☐☐ Frequent Colds or Flu
- ☐☐☐ Herpes/Cold Sores
- ☐☐☐ Measles
- ☐☐☐ Mumps
- ☐☐☐ Veneral Disease
- ☐☐☐ Malaria
- ☐☐☐ Diptheria
- ☐☐☐ Cancer

### O F C *CARDIOVASCULAR*

- ☐☐☐ High Blood Pressure
- ☐☐☐ Low Blood Pressure
- ☐☐☐ Chest Pain
- ☐☐☐ Hardening of Arteries
- ☐☐☐ Poor Circulation
- ☐☐☐ Rapid or Irregular Heart Beat
- ☐☐☐ Slow Heart Beat
- ☐☐☐ Ankle Swelling
- ☐☐☐ Heart Disease
- ☐☐☐ Heart Attack
- ☐☐☐ Stroke

### O F C *RESPIRATORY*

- ☐☐☐ Difficult Breathing
- ☐☐☐ Chronic Cough
- ☐☐☐ Mucous/Phlegm
- ☐☐☐ Wheezing
- ☐☐☐ Asthma
- ☐☐☐ Pneumonia
- ☐☐☐ Emphysema
- ☐☐☐ Tuberculosis
- ☐☐☐ Pleurisy

### O F C *SKIN*

- ☐☐☐ Itching
- ☐☐☐ Hives/Allergy
- ☐☐☐ Rash/Eruptions
- ☐☐☐ Eczema
- ☐☐☐ Acne
- ☐☐☐ Boils
- ☐☐☐ Bruise Easily
- ☐☐☐ Dryness
- ☐☐☐ Varicose Veins
- ☐☐☐ Hair Loss

### O F C *GENITO-URINARY*

- ☐☐☐ Frequent Urination
- ☐☐☐ Inability to Control Kidneys
- ☐☐☐ Kidney Infection or Stones
- ☐☐☐ Painful Urination
- ☐☐☐ Bed-Wetting
- ☐☐☐ Blood in Urine
- ☐☐☐ Prostate Trouble
- ☐☐☐ Impotence

### O F C *FOR WOMEN ONLY*

- ☐☐☐ P.M.S.
- ☐☐☐ Menstrual Pain
- ☐☐☐ Irregular Menstruation
- ☐☐☐ Menopausal Symptoms
- ☐☐☐ Hot Flashes
- ☐☐☐ Congested/Sore Breasts
- ☐☐☐ Vaginal Discharge
- ☐☐☐ Other Female Disorder
- ☐☐☐ Miscarriage
- ☐ No ☐ Yes *Are You Pregnant?*