

# Confidential Patient Case History

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

Name \_\_\_\_\_ Date \_\_\_\_\_

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**

**GENERAL**

- 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
- 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

**O F C**

**GASTRO-INTESTINAL**

- 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 noises
- 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

**O F C**

**CARDIO-VASCULAR**

- Hardening of 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**

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes  No Are you pregnant?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores     | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Whooping cough   |

**PLEASE PRINT**

What's your major complaint? \_\_\_\_\_

List surgical operation and years: \_\_\_\_\_

Drugs you now take:  Nerve pills  Pain killers  Muscle relaxers  "Pep" pills  Tranquilizers  Birth control pills

Others: \_\_\_\_\_

Age of mattress: \_\_\_\_\_  Comfortable  Uncomfortable  Do you use a bed board? \_\_\_\_\_

Are you wearing:  Heal lifts  Sole lifts  Inner soles  Arch supports

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? \_\_\_\_\_

	Yes	No	DESCRIBE BRIEFLY
<b>HAVE YOU EVER:</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for anything other than surgery?			_____

<b>DO YOU:</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?			_____

<b>DATE OF LAST:</b>	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X- ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test				

<b>HABITS:</b>	Coffee	Drugs	Sleep
Alcohol	Tobacco	Exercise	Appetite

Heavy

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Moderate

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Light

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None

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IN CASE OF EMERGENCY: (Name of relative or close friend **not** living in your home):

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_