

**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.

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| **Date:** | Click here to enter a date. |
| **First Name** | Enter First Name | **Initial** | MI | **Last Name** | Enter Last Name |
| **e-mail** |  |
| Home Information |
| **Street** | Enter Street Address |
| **Apartment or Suite** | Enter Apartment or Suite Number |
| **City** | Enter City | **State** | Enter State | **Zip** | Enter Zip |
| **Home Phone** | Enter Home Phone | **Cell Phone** | Enter Cell Phone |
| Work Information |
| **Employer** | Enter Employer | **Your Occupation** | Enter Your Occupation |
| **Street** | Enter Street Address |
| **Suite** | Enter Suite Number |
| **City** | Enter City | **State** | Enter State | **Zip** | Enter Zip |
| **Work Phone** | Enter Work Phone | **How Long In This Job** | Enter Work Phone |
| Personal Information |
| **Age** | Enter Age | **Date of Birth** | Enter DOB | **State or Country** | Enter State / Country |
| **SSN** | Enter SSN | **Sex** | [ ] M [ ]  F  | **Height** | Enter Height | **Weight** | Enter Weight |
| **Spouses Name (if Married)** | Enter Spouses Name |
| **Nearest Relative NOT Living With You** | Enter Relative’s Name | **Their Phone** | Enter Their Phone |
| **Family Physicians Name (if any)** | Enter Physicians Name |
| **Who To Contact In Case of Emergency** | Enter Emergency Contact | **Their Phone** | Enter Their Phone |
| **Who to Thank for Referring You To Our Office?** | Enter Referral’s Name if Any |

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 heath before we accept your case. **THIS IS A CONFIDENTIAL HEALTH REPORT**.

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **GENERAL** |
|[ ] [ ] [ ] [ ]  Allergy |
|[ ] [ ] [ ] [ ]  Convulsions |
|[ ] [ ] [ ] [ ]  Dizziness |
|[ ] [ ] [ ] [ ]  Fainting |
|[ ] [ ] [ ] [ ]  Headache |
|[ ] [ ] [ ] [ ]  Numbness |

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **MUSCLE AND JOINT** |
|[ ] [ ] [ ] [ ]  Arthritis |
|[ ] [ ] [ ] [ ]  Bursitis |
|[ ] [ ] [ ] [ ]  Foot Trouble |
|[ ] [ ] [ ] [ ]  Low Back Pain |
|[ ] [ ] [ ] [ ]  Neck pain or stiffness |
|[ ] [ ] [ ] [ ]  Pain between shoulders |
|  Pain or Numbness In: |
|[ ] [ ] [ ] [ ]  Shoulders |
|[ ] [ ] [ ] [ ]  Arms |
|[ ] [ ] [ ] [ ]  Elbows |
|[ ] [ ] [ ] [ ]  Hands |
|[ ] [ ] [ ] [ ]  Hips |
|[ ] [ ] [ ] [ ]  Legs |
|[ ] [ ] [ ] [ ]  Knees |
|[ ] [ ] [ ] [ ]  Feet |
|[ ] [ ] [ ] [ ]  Sciatica (deep upper leg pain) |
|[ ] [ ] [ ] [ ]  Swollen joints |

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **GASTRO-INTESTINAL** |
|[ ] [ ] [ ] [ ]  Colon trouble |
|[ ] [ ] [ ] [ ]  Constipation |
|[ ] [ ] [ ] [ ]  Diarrhea |
|[ ] [ ] [ ] [ ]  Difficult digestion |
|[ ] [ ] [ ] [ ]  Distension of abdomen |
|[ ] [ ] [ ] [ ]  Gall bladder trouble |
|[ ] [ ] [ ] [ ]  Hemorrhoids |
|[ ] [ ] [ ] [ ]  Liver trouble |
|[ ] [ ] [ ] [ ]  Pain over stomach |

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **EYES, EARS, NOSE & THROAT** |
|[ ] [ ] [ ] [ ]  Colds |
|[ ] [ ] [ ] [ ]  Deafness |
|[ ] [ ] [ ] [ ]  Earache |
|[ ] [ ] [ ] [ ]  Ear discharge |
|[ ] [ ] [ ] [ ]  Ear noises |
|[ ] [ ] [ ] [ ]  Eye pain |
|[ ] [ ] [ ] [ ]  Sore throat |
|[ ] [ ] [ ] [ ]  Nosebleeds |
|[ ] [ ] [ ] [ ]  Sinus infection |

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **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 |

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **RESPIRATORY** |
|[ ] [ ] [ ] [ ]  Chest pain |
|[ ] [ ] [ ] [ ]  Chronic cough |
|[ ] [ ] [ ] [ ]  Asthma |
|[ ] [ ] [ ] [ ]  Spitting up blood |
|[ ] [ ] [ ] [ ]  Spitting up phlegm |
|[ ] [ ] [ ] [ ]  Wheezing |

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **GENITO-URINARY** |
|[ ] [ ] [ ] [ ]  Bed-wetting |
|[ ] [ ] [ ] [ ]  Blood in urine |
|[ ] [ ] [ ] [ ]  Frequent urination |
|[ ] [ ] [ ] [ ]  Inability to control kidneys |
|[ ] [ ] [ ] [ ]  Kidney infection or stones |
|[ ] [ ] [ ] [ ]  Painful urination |
|[ ] [ ] [ ] [ ]  Prostate trouble |
|[ ] [ ] [ ] [ ]  Pus in urine |

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **SKIN** |
|[ ] [ ] [ ] [ ]  Bruise easily |
|[ ] [ ] [ ] [ ]  Dryness |
|[ ] [ ] [ ] [ ]  Skin eruptions (rash) |
|[ ] [ ] [ ] [ ]  Varicose veins |
|[ ] [ ] [ ] [ ]  Dandruff |

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| **IN THE PAST** | **NEVER** | **OCCASIONAL** | **FREQUENT** | **FOR WOMEN ONLY** |
|[ ] [ ] [ ] [ ]  Congested breasts or tender |
|[ ] [ ] [ ] [ ]  Cramps or backache |
|[ ] [ ] [ ] [ ]  Excessive menstrual flow |
|[ ] [ ] [ ] [ ]  Hot flashes |
|[ ] [ ] [ ] [ ]  Irregular cycle |
|[ ] [ ] [ ] [ ]  Lumps in breast |
|[ ] [ ] [ ] [ ]  Menopausal symptoms |
|[ ] [ ] [ ] [ ]  Painful menstruation |
|[ ] [ ] [ ] [ ]  Vaginal discharge |

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

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| [ ] Alcoholism | [ ] Chicken pox | [ ] Goiter | [ ] Miscarriage | [ ] Rheumatic fever |
| [ ] Anemia | [ ] Diabetes | [ ] Gout | [ ] Mumps | [ ] Stroke |
| [ ] Appendicitis | [ ] Eczema | [ ] Heart Disease | [ ] Multiple sclerosis | [ ] Tuberculosis |
| [ ] Cancer | [ ] Emphysema |  | [ ] Polio | [ ] Ulcers |

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| **Describe major complaints and symptoms:** | Describe here |
| **Date you first noticed symptoms:** | Enter date noticed here |
| **Has this happened before?** | [ ] Yes [ ] No | **When?**  | Enter when here |

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| **Drugs you now take**: | [ ] Pain killers | [ ] Anti-Inflammatories |
|  | [ ] Muscle relaxers | [ ] “Pep” pills |
|  | [ ] Tranquilizers | [ ] Insulin |
|  | [ ] Birth control pills |  |
|  | **Other**: | Enter other drugs here |

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| **Age of mattress** | Enter age here | [ ] **Comfortable** [ ] **Uncomfortable** |

**Are you wearing:** [ ] Heel lifts [ ] Arch supports**Have you been in an auto accident?**[ ] Past year [ ] Past 5 years [ ] Over 5 years [ ] Never**Have you ever had any mental or emotional disorders?** [ ] Yes [ ] No

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| **HAVE YOU EVER:** | Yes | No |
| Been knocked unconscious? |[ ] [ ]
| Used a crutch, or other support? |[ ] [ ]
| Been treated for a spine or nerve disorder? |[ ] [ ]
| Had a fractured bone? |[ ] [ ]
| Been hospitalized for other than surgery? |[ ] [ ]
| Ever had surgery? |[ ] [ ]

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| **DATE OF LAST:** | Less than 6 mos. | 6-18 mos. | Over 18 mos. | Never |
| Spinal examination |[ ] [ ] [ ] [ ]
| Physical examination |[ ] [ ] [ ] [ ]
| Blood test |[ ] [ ] [ ] [ ]
| Chest x-ray |[ ] [ ] [ ] [ ]
| Spinal x-ray |[ ] [ ] [ ] [ ]
| Dental x-ray |[ ] [ ] [ ] [ ]
| Urine test |[ ] [ ] [ ] [ ]

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| **Habits:** | Heavy | Moderate | Light | None |
| Alcohol |[ ] [ ] [ ] [ ]
| Coffee |[ ] [ ] [ ] [ ]
| Tobacco |[ ] [ ] [ ] [ ]
| Exercise |[ ] [ ] [ ] [ ]
| Sleep |[ ] [ ] [ ] [ ]
| Appetite |[ ] [ ] [ ] [ ]

 | Office Use |

After reading and filling out case history, your signature will verify that all information you have given us is accurate and that you have read the case history questions entirely.

Sign Your Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: Click for Date

**FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENST ARE MADE**