denito
chiropractic clinic, pc

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.

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**.

IN THE PAST	NEVER	OCCASIONAL	FREQUENT	GENERAL
☐	☐	☐	☐	Allergy
☐	☐	☐	☐	Convulsions
☐	☐	☐	☐	Dizziness
☐	☐	☐	☐	Fainting
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Numbness

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

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

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

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

IN THE PAST	NEVER	OCCASIONAL	FREQUENT	RESPIRATORY
☐	☐	☐	☐	Chest pain
☐	☐	☐	☐	Chronic cough
☐	☐	☐	☐	Asthma
☐	☐	☐	☐	Spitting up blood
☐	☐	☐	☐	Spitting up phlegm
☐	☐	☐	☐	Wheezing

IN THE PAST	NEVER	OCCASIONAL	FREQUENT	SKIN
☐	☐	☐	☐	Bruise easily
☐	☐	☐	☐	Dryness
☐	☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	☐	Varicose veins
☐	☐	☐	☐	Dandruff

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

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

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:

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

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

Drugs you now take: ☐Pain killers ☐Anti-Inflammatories
☐Muscle relaxers ☐"Pep" pills
☐Tranquilizers ☐Insulin
☐Birth control pills
Other: Enter other drugs here

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

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?	☐	☐

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	☐	☐	☐	☐

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