

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.
(Please Print)

NAME _____ (last) _____ (first) _____ (middle) DATE _____

HOME ADDRESS _____ (apt. #) _____ (city) _____ (state) _____ (zip)

HOME PHONE _____ WORK PHONE _____

WORK ADDRESS/NAME _____

SOCIAL SECURITY No. _____ OCCUPATION _____

(age) (date of birth) (sex) (ht.) (wt.) HOW MANY CHILDREN _____

SPOUSE'S NAME _____ WORK PHONE _____

SPOUSE'S WORK ADDRESS _____

PHYSICIAN'S PHONE _____ DENTIST'S PHONE _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

NEAREST FRIEND NOT LIVING WITH YOU _____ PHONE _____

WHO TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

WHO TO THANK FOR REFERRING YOU _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS CARE? WORKER'S COMP. _____ AUTO INS. _____

ME +/-or MY PERSONAL/GROUP INS. _____ OTHER _____

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.

IN PAST NEVER OCCASIONAL FREQUENT	GENERAL <input type="checkbox"/> Allergy <input type="checkbox"/> Convulsions <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headache <input type="checkbox"/> Numbness MUSCLE & JOINT <input type="checkbox"/> Arthritis <input type="checkbox"/> Bursitis <input type="checkbox"/> Foot Trouble <input type="checkbox"/> Low back pain <input type="checkbox"/> Neck pain or stiffness <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Pain or numbness in: <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms <input type="checkbox"/> Elbows <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Knees <input type="checkbox"/> Feet <input type="checkbox"/> Sciatica (deep upper leg pain) <input type="checkbox"/> Swollen joints	GASTRO-INTESTINAL <input type="checkbox"/> Colon trouble <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficult digestion <input type="checkbox"/> Distension of abdomen <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver trouble <input type="checkbox"/> Pain over stomach EYES, EARS, NOSE & THROAT <input type="checkbox"/> Colds <input type="checkbox"/> Deafness <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Ear noises <input type="checkbox"/> Eye pain <input type="checkbox"/> Sore throat <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus infection CARDIO-VASCULAR <input type="checkbox"/> Hardening of arteries <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Pain over heart <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Slow heart beat <input type="checkbox"/> Swelling of ankles	RESPIRATORY <input type="checkbox"/> Chest Pain <input type="checkbox"/> Chronic cough <input type="checkbox"/> Asthma <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> Wheezing SKIN <input type="checkbox"/> Bruise easily <input type="checkbox"/> Dryness <input type="checkbox"/> Skin eruptions (rash) <input type="checkbox"/> Varicose veins <input type="checkbox"/> Dandruff GENITO-URINARY <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Inability to control kidneys <input type="checkbox"/> Kidney infection or stones <input type="checkbox"/> Painful urination <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Pus in urine FOR WOMEN ONLY <input type="checkbox"/> Congested breasts or tender <input type="checkbox"/> Cramps or backache <input type="checkbox"/> Excessive menstrual flow <input type="checkbox"/> Hot flashes <input type="checkbox"/> Irregular cycle <input type="checkbox"/> Lumps in breast <input type="checkbox"/> Menopausal symptoms <input type="checkbox"/> Painful menstruation <input type="checkbox"/> Vaginal discharge
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CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Mumps	<input type="checkbox"/> Stroke
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema		<input type="checkbox"/> Polio	<input type="checkbox"/> Ulcers

(Please complete other side)

CASE HISTORY

PLEASE PRINT

Describe major complaints and symptoms _____

Date you first noticed symptoms _____

Has this happened before? _____ When _____

Office Use

Drugs you now take: Pain killers Anti-inflammatory
 Muscle relaxers "Pep" pills
 Tranquilizers Insulin
 Birth control pills
other _____

Age of mattress _____ 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 had any serious personal injury or accident? Past year
 Past 5 years Over 5 years None

Have you ever had any mental or emotional disorders? Yes
 No

HAVE YOU EVER:

Been knocked unconscious? Yes No
Used a crutch, or other support Yes No
Been treated for a spine or nerve disorder? Yes No
Had a fractured bone? Yes No
Been hospitalized for other than surgery? Yes No
Ever had surgery? Yes No

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

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 _____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE