

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 you as a patient. Thank You.

Full Name: _____ Called: _____ DOB: _____ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

SSN#: _____ Marital Status: S M W D Sep Spouses name: _____

Your Employer: _____ Your Occupation: _____

Employer address: _____ City: _____ State: _____ Zip: _____

Person responsible for this account: _____ Referred By: _____ **E-mail:** _____

History of Present Injury/Illness: Please list below the complaint(s) you have in order of importance, also the length of time you had these complaint(s).

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____
4. _____ How Long? _____

Is your condition related to an accident? Yes No If yes describe: _____

Ever had a similar episode before? Yes No Describe your condition: getting worse the same getting better constant comes + goes

What activities aggravate your condition? _____ What makes your condition better? _____

Is this condition interfering with your: Work Sleep Daily routine Other: _____

Have you seen any other health care provider for your present condition? Yes No Who? _____

List previous diagnoses and treatments you have received for your present condition? _____

List all medications you presently take: _____

Age of your mattress: _____ type of mattress: _____ Comfortable Uncomfortable Are you wearing: heel lifts arch supports

Past History: List any surgeries you have had

1. _____ Date: _____ 3. _____ Date: _____
2. _____ Date: _____ 4. _____ Date: _____

Have you ever been involved in a motor vehicle accident? Past year Past five years Over five years Never

Describe: _____

Have you ever:	Yes	No	Describe Briefly:
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a crutch, cane, 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 fracture or broken bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitalized other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you:	Yes	No	Describe Briefly:
Now take vitamins, minerals, or herbs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Think you may need supplements?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Habits:	Heavy	Moderate	Light	None	Comments:
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

In case of an emergency who should we contact?

Name: _____

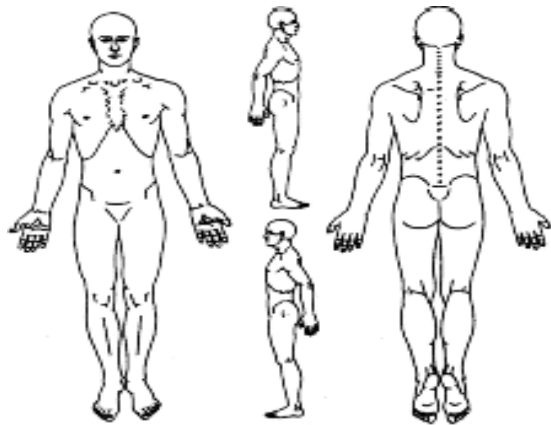
Relationship: _____

Address: _____

Phone #: _____

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Please check the appropriate box for any of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. This is a confidential health report.



On the drawing to the right, circle the area(s) where you have pain. Then, *for each area that you have circled*, designate a number from 0 to 10 (with 10 being the most pain) that corresponds to your *current* pain level.

0-10	Burning	Sharp	Numb	Tingling	Ache	Other
___ Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Low back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P – Previous C – Current

- P C**
- General**
- Allergy / Hay fever
 - Convulsions / Tremors
 - Dizziness
 - Depression / Anxiety
 - Fainting
 - Fatigue
 - Insomnia
 - Loss of Weight
 - Night Sweats
- Muscle & Joint**
- Arthritis
 - Bursitis / Swollen Joints
 - Night Pain
 - Muscle cramps at night
 - Muscle weakness
 - Scoliosis
 - Stiffness
 - Surgical implant

- P C**
- Gastro-Intestinal**
- Belching or gas
 - Bloating after meals
 - Constipation / Diarrhea
 - Gall bladder removed
 - Colitis
- EENT**
- Deviated septum
 - Frequent colds / ear infections
 - Nosebleeds
 - Tinnitus
- Endocrine**
- Afternoon headaches
 - Crave salt
 - Coarse or thinning hair
 - Get “shaky” if hungry
 - Inability to concentrate
 - Increase in weight
 - Sensitive to cold
- Skin**
- Bruise easily
 - Hives / rash

- P C**
- Cardio-Vascular**
- Asthma
 - Chest Pain
 - Chronic cough
 - Difficulty breathing / Wheezing
 - Hardening of arteries
 - High / Low blood pressure
 - Pain over heart / chest pain
 - Spitting up blood / phl egm
 - Swelling of ankles
- Genito-urinary**
- Bed-wetting
 - Unable to control kidneys
 - Painful urination
 - Frequent urination
 - Prostate trouble
- For Women Only**
- Hot flashes
 - Irregular / Painful / Excessive menses
 - Painful breasts
 - Premenstrual tension
- Yes No Are you pregnant?

Family History: Check the following condition that applies for you, mother, and father

	You	Father	Mother	explain
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Pace maker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

- I have read the Consent to Treatment for chiropractic and acupuncture and I have freely decided to undergo the recommended treatment.
- I allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I’ve been informed and understand my rights concerning HIPPA Notice of Privacy Practices, and Use and Disclosure of Protected Health Information. (Once information is disclosed, it may not be protected by law.)
- I give this office authorization to use my name for any in-office publications.
- Authorization may be denied or retracted at any time by notifying the office manager.
- I authorize payment of medical benefits to this office.

Patient signature: _____

Date: _____

Guardian’s signature: _____

Date: _____

(Authorization expires 3 years from above date)