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. 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. OFC OFC O - OCCASIONAL F - FREQUENT **CARDIO-VASCULAR C - CONSTANT** GASTRO-INTESTINAL □ □ □ Hardening of arteries □ □ □ Belching or gas ☐ ☐ ☐ High blood pressure □ □ □ Colitis OFC □ □ □ Colon trouble □ □ □ Low blood pressure **GENERAL** □ □ □ Constipation □ □ □ Pain over heart □ □ □ Allergy □ □ □ Poor circulation □ □ □ Diarrhea ☐ ☐ ☐ Chills □ □ □ Rapid heart beat □ □ □ Convulsions □ □ □ Difficult digestion ☐ ☐ ☐ Slow heart beat □ □ □ Dizziness □ □ □ Distension of abdomen □ □ □ Swelling of ankles □ □ □ Fainting □ □ □ Excessive hunger RESPIRATORY □ □ Gall bladder trouble □ □ □ Fatigue □ □ □ Chest pain □ □ □ Hemorrhoids □ □ □ Fever □ □ □ Chronic cough □ □ □ Intestinal worms □ □ □ Headache □ □ □ Difficult breathing ☐ ☐ ☐ Jaundice □ □ □ Loss of sleep ☐ ☐ ☐ Spitting up blood □ □ □ Liver trouble □ □ □ Loss of weight ☐ ☐ ☐ Spitting up phlegm □ □ □ Nausea □ □ □ Nervousness/depression □ □ □ Wheezing □ □ □ Neuralgia ☐ ☐ ☐ Pain over stomach □ □ □ Poor appetite SKIN □ □ □ Numbness □ □ □ Vomiting □ □ □ Boils □ □ □ Sweats ☐ ☐ ☐ Bruise easily ☐ ☐ ☐ Vomiting of blood □ □ □ Tremors □ □ □ Dryness **EYES, EARS, NOSE MUSCLE & JOINT** ☐ ☐ ☐ Hives or allergy □ □ □ Arthritis &THROAT □ □ □ Itching □ □ □ Asthma □ □ □ Bursitis □ □ □ Colds Skin eruptions (rash) □ □ □ Foot trouble □ □ □ Varicose veins □ □ □ Crossed eyes □ □ □ Hernia **GENITO-URINARY** □ □ □ Deafness □ □ Low back pain □ □ □ Bed-wetting □ □ □ Dental Decay ☐ ☐ ☐ Lumbago ☐ ☐ ☐ Blood in urine □ □ □ Neck pain or stiffness □ □ □ Earache ☐ ☐ ☐ Frequent urination □ □ □ Ear discharge □ □ □ Pain between shoulders □ □ □ Ear noises □ □ □ Inability to control kidneys Pain or numbness in: Shoulders □ □ □ Enlarged glands ☐ ☐ ☐ Kidney infection or stones □ □ □ Painful urination □ □ □ Enlarged thyroid Arms ☐ ☐ ☐ Eye pain □ □ □ Prostate trouble Elbows □ □ □ Pus in urine ☐ ☐ ☐ Failing vision Hands FOR WOMEN ONLY ☐ ☐ ☐ Far sightedness Hips □ □ □ Congested breasts ☐ ☐ Gum trouble Legs □ □ □ Cramps or backache ☐ ☐ ☐ Hay fever Knees □ □ □ Hoarseness □ □ □ Excessive menstrual flow Feet □ □ □ Nasal obstruction □ □ □ Hot flashes ☐ ☐ ☐ Painful tail bone □ □ □ Near sightedness □ □ □ Irregular cycle □ □ □ Poor posture □ □ □ Nosebleeds □ □ □ Menopausal symptoms □ □ □ Sciatica □ □ □ Sinus infection ☐ ☐ ☐ Painful menstruation □ □ □ Spinal Curvature □ □ □ Sore throat □ □ □ Vaginal discharge □ □ □ Swollen joints □ □ □ Tonsillitis ☐ Yes ☐ No Are you pregnant? **CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:** ☐ Scarlet fever ☐ Cold sores ☐ Goiter ☐ Miscarriage ☐ Alcoholism ■ Multiple sclerosis □ Stroke □ Gout ☐ Anemia □ Diabetes □ Tuberculosis □ Diphtheria ☐ Heart disease □ Mumps □ Appendicitis □ Typhoid fever □ Eczema □ Influenza □ Pleurisy □ Arteriosclerosis □ Ulcers ☐ Arthritis ☐ Emphysema □ Lumbago □ Pneumonia ☐ Venereal disease ☐ Polio □ Epilepsy ☐ Malaria □ Cancer

☐ Measles

☐ Fever blisters

□ Chorea

☐ Whooping cough

☐ Rheumatic fever

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List surgical operation and years	s:			
Drugs you now take: Nerve	n" nills 🔲 Tranquilizers 📙	Birth control pills		
Are you wearing:	ts □ Sole lifts □ Inner lent: □ Past year □ P	rsoles LI Alcii Suppoi i	Do you use a bed board?s s five years	_
Describe: Have you ever had any mental Have others in your fa	ar amotional disorders? [Yes □ No When		
HAVE YOU EVER: Been knocked unconscious? Used a cane, crutch, or other s Been treated for a spine or net Had a fractured bone? Been hospitalized for anything	rve disorder?	Yes No	DESCRIBE BRIEFLY	
DO YOU: Now take vitamins or minera Think you may need vitamins Have an allergy to any drug?	s or minerals?			
DATE OF LAST: Spinal examination Physical examination Blood test Chest X- ray Spinal X-ray Dental X-ray	Less than 6 months	6-18 months	Over 18 months	Never
Urine test HABITS Alcohol Coffee Tobacco Drugs Exercise Sleep Appetite	Heavy	Moderate □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Light	None
IN CASE OF EMERGENCY: (Na	ame of relative or close frien	d not living in your hom e	e): NAME	
ADDRESS.	PHONE:			