

# 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.

NAME ..... HOME PHONE .....

ADDRESS ..... CITY ..... WORK PHONE .....

DATE OF BIRTH ..... AGE ..... M ..... F ..... MARITAL STATUS ..... No. of CHILDREN .....

OCCUPATION ..... REFERRED BY .....

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.

OCCASIONAL  
FREQUENT  
CONSTANT

### GENERAL

- |                          |                          |                          |                        |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergy                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chills                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of sleep          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of weight         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness/depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuralgia              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sweats                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tremors                |

### MUSCLE & JOINT

- |                          |                          |                          |                        |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bursitis               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foot trouble           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hernia                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low back pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumbago                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck pain or stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain between shoulders |

### Pain or numbness in:

- |                          |                          |                          |                   |
|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shoulders         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arms              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Elbows            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hands             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hips              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Legs              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Knees             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feet              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful tail bone |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor posture      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sciatica          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spinal curvature  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints    |

### GASTRO-INTESTINAL

- |                          |                          |                          |                       |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Belching or gas       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colitis               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colon trouble         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficult digestion   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Distension of abdomen |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive hunger      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall-bladder trouble  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intestinal worms      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver trouble         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain over stomach     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor appetite         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting of blood     |

### EYES, EARS, NOSE & THROAT

- |                          |                          |                          |                   |
|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colds             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crossed eyes      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Deafness          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental decay      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Earache           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear discharge     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear noises        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged glands   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged thyroid  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failing vision    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Far sightedness   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gum trouble       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nasal obstruction |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Near sightedness  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus infection   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sore throat       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis       |

### CARDIO-VASCULAR

- |                          |                          |                          |                       |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hardening of arteries |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain over heart       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Slow heart beat       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles    |

### RESPIRATORY

- |                          |                          |                          |                     |
|--------------------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficult breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spitting up blood   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spitting up phlegm  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing            |

### SKIN

- |                          |                          |                          |                       |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Boils                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dryness               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hives or allergy      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Itching               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin eruptions (rash) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins        |

### GENITO-URINARY

- |                          |                          |                          |                              |
|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed-wetting                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inability to control kidneys |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney infection or stones   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostrate trouble            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pus in urine                 |

### FOR WOMEN ONLY

- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Congested breasts        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps or backache       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hot flushes              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular cycle          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumps in breast          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menopausal symptoms      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful menstruation     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge        |

### CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores     | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Whooping cough   |

Have you ever had previous chiropractic care? ..... If yes, date of last care .....

Do you have Health and Accident Insurance? ..... If yes, with what company? .....

Is this an Industrial Accident Case?  Yes  No

(Please complete other side)

**PLEASE PRINT**

What is your major complaint? .....

Other complaints .....

How long have you had this condition? ..... Have you had this or similar conditions in the past? .....

What activities aggravate your condition? .....

Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes

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

How long has it been since you really felt good? .....

What do you believe is wrong with you? .....

List surgical operations and years: .....

Drugs you now take:  Nerve pills  Pain killers  Muscle relaxers  "Pep" pills  Tranquilisers  
 Insulin  Birth control pills  Others .....

Dental visits:  Every 6 mths.  Yearly  Toothache or "emergency" only  Complete dentures

Age of mattress .....  Comfortable  Uncomfortable Do you use a bed board? .....

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch supports

Have you been in an auto accident?  Past year  Past 5 years  Over 5 years  Never

Describe .....

Have you had any other personal injury or accident?  Past year  Past 5 years  Over 5 years  None

Describe .....

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

Have others in your family had such disorders?  Yes  No When? .....

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Used a cane, crutch, 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 fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Been hospitalised for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	.....
DO YOU:			
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	.....
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	.....

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	Heavy	Moderate	Light	None	LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS:
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"/>	.....
Sleep	<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 EMERGENCY:  
 (Name of relative or close friend not living in your home):

NAME ..... ADDRESS ..... PHONE .....