



## CONFIDENTIAL PATIENT CASE HISTORY

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 \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation: \_\_\_\_\_ # of Children \_\_\_\_\_ Marital Status: **M S W D P**

Spouse's Name \_\_\_\_\_ Referred by \_\_\_\_\_

Emergency Contact & Phone # \_\_\_\_\_

**HEALTH INFORMATION: Have you had previous chiropractic care?**  Yes  No

What is your major complaint? \_\_\_\_\_

**Please indicate on the pictures to the right the areas of your complaints.**

Is the Pain:  Sharp  Dull  Throbbing  Stabbing  Burning  Aching  Tender

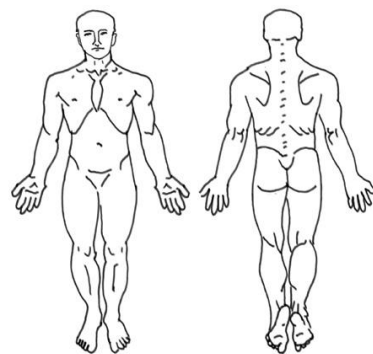
Is your condition getting worse?  Yes  No Is it:  Constant  Comes&Goes

Is this condition interfering with your:  Work  Sleep  Daily Routine  Other

What activities aggravate your condition?  Sitting  Exercise  Walking

Driving  Worse in AM  Worse in PM  Standing  Cough/Sneezing

Associated Symptoms:  Numbness  Tingling  Swelling  Other \_\_\_\_\_



On a scale of 1 to 10 (10 being the worst pain you can imagine) rate your pain: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past?  Yes  No

Does anything help lessen or relieve the pain/symptoms? \_\_\_\_\_

Other Complaints: \_\_\_\_\_

Other doctors who treated this condition? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Age of mattress \_\_\_\_\_  Comfortable  Uncomfortable Are you wearing:  Heel lifts  Orthotics

Have you ever had an auto accident or any other personal injury or accident?  Yes  Never

Describe: \_\_\_\_\_

**Medications:** Please select all medications that you are currently taking:

- None Advil Ambien Analgesics Anti-inflammatories Anti-Anxiety Anti-Depression Aspirin Asthma
- Atenolol Birth control Blood Pressure Medication Daily Vitamins Diabetes Medication Muscle Relaxers
- Pain Medication Sleep Aid Synthroid Tylenol Vicodin
- Other \_\_\_\_\_

**Allergies Please List:** \_\_\_\_\_

**Do you use:** Tobacco Alcohol Coffee

**Past Medical History:** Please select all conditions that you have had or are currently having:

- Weight loss/gain General Fatigue Fever/Chills Weakness Rashes Lumps Itching Dry skin Dermatitis Eczema
- Headache Head Injury Hearing Changes Earaches Tinnitus (ringing in ears) Visual Problems Cataracts
- Glaucoma Nosebleeds Sinus Pain Dry mouth Sore throat Neck Pain Swollen glands Breast Pain/lumps Cough
- Asthma Lung Problems Cardiovascular disease/heart attack Chest Pain Hypertension Shortness of breath
- Swallowing Problems Heartburn Nausea Abdominal Pain Rectal Bleeding Change in bowel habits
- Loss of Bladder/Bowel Control Change in Urinary frequency/urgency Bladder/Urinary Blood in Urine Incontinence
- Kidney Disorders Thyroid Liver/Gallbladder Hernia Testicular pain/lumps Erectile Dysfunction Prostate Problems
- Hot Flashes STD's Calf pain with walking Leg cramping Blood Disorder Stroke Cancer
- Tumor Ulcer Diabetes High Cholesterol Arthritis Muscle/joint pain Swollen/Stiff Joints Back Pain Scoliosis
- Trauma Dizziness Fainting Seizures Numbness Tingling Tremor Ease of bruising/bleeding
- Heat/Cold intolerance Sweating Thirst Change in appetite Anxiety Depression Nervousness Memory loss
- Stress Other \_\_\_\_\_

Date of Last Physical Examination: \_\_\_\_\_ Dental Exam: \_\_\_\_\_ Vision Exam: \_\_\_\_\_

**FAMILY HEALTH INFORMATION:** (Please list any family members who have or had conditions such as Cancer, Heart Disease, Diabetes, Lung Disease or disorders, Back Problems, or other health issues)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

**INSURANCE INFORMATION:**

Is your condition due to an auto accident or job related injury?  Yes  No

Do you have Health Insurance?  Yes  No

If yes, **Name of Health Insurance Company:** \_\_\_\_\_

**Policy #** \_\_\_\_\_

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouses Signature: \_\_\_\_\_ Date \_\_\_\_\_ S.S # \_\_\_\_\_

Doctors Signature: \_\_\_\_\_ Date \_\_\_\_\_