Confidential Patient Case History

NAME _____ DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ WORK PHONE _____

DATE OF BIRTH _____ AGE ____ M ____ F ____ MARITAL STATUS _____ NO. OF CHILDREN _____

[redacted] _____ OCCUPATION _____ REFERRED BY _____

FAX _____ E-MAIL _____ CELL PHONE _____

OCCASIONAL
FREQUENT
CONSTANT

GENERAL

- ☐☐☐ Allergy
- ☐☐☐ Chills
- ☐☐☐ Convulsions
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Fever
- ☐☐☐ Headache
- ☐☐☐ Loss of sleep
- ☐☐☐ Loss of weight
- ☐☐☐ Nervousness/depression
- ☐☐☐ Neuralgia
- ☐☐☐ Numbness
- ☐☐☐ Sweats
- ☐☐☐ Tremors

MUSCLE & JOINT

- ☐☐☐ Arthritis
- ☐☐☐ Bursitis
- ☐☐☐ Foot trouble
- ☐☐☐ Hernia
- ☐☐☐ Low back pain
- ☐☐☐ Lumbago
- ☐☐☐ Neck pain or stiffness
- ☐☐☐ Pain between shoulders
- Pain or numbness in:
  - ☐☐☐ Shoulders
  - ☐☐☐ Arms
  - ☐☐☐ Elbows
  - ☐☐☐ Hands
  - ☐☐☐ Hips
  - ☐☐☐ Legs
  - ☐☐☐ Knees
  - ☐☐☐ Feet
- ☐☐☐ painful tail bone
- ☐☐☐ Poor posture
- ☐☐☐ Sciatica
- ☐☐☐ Spinal curvature
- ☐☐☐ Swollen joints

GASTRO-INTESTINAL

O F C

- ☐☐☐ Belching or gas
- ☐☐☐ Colitis
- ☐☐☐ Colon trouble
- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Difficult digestion
- ☐☐☐ Distension of abdomen
- ☐☐☐ Excessive hunger
- ☐☐☐ Gall bladder trouble
- ☐☐☐ Hemorrhoids
- ☐☐☐ Intestinal worms
- ☐☐☐ Jaundice
- ☐☐☐ Liver trouble
- ☐☐☐ Nausea
- ☐☐☐ Pain over stomach
- ☐☐☐ Poor Appetite
- ☐☐☐ Vomiting
- ☐☐☐ Vomiting of blood

EYES, EARS, NOSE & THROAT

- ☐☐☐ Asthma
- ☐☐☐ Colds
- ☐☐☐ Crossed eyes
- ☐☐☐ Deafness
- ☐☐☐ Dental decay
- ☐☐☐ Earache
- ☐☐☐ Ear discharge
- ☐☐☐ Ear noises
- ☐☐☐ Enlarged glands
- ☐☐☐ Enlarged thyroid
- ☐☐☐ Eye pain
- ☐☐☐ Failing vision
- ☐☐☐ Far sightedness
- ☐☐☐ Gum trouble
- ☐☐☐ Hayfever
- ☐☐☐ Hoarseness
- ☐☐☐ Nasal obstruction
- ☐☐☐ Near sightedness
- ☐☐☐ Nosebleeds
- ☐☐☐ Sinus infection
- ☐☐☐ Sore throat
- ☐☐☐ Tonsillitis

CARDIO-VASCULAR

O F C

- ☐☐☐ Hardening of arteries
- ☐☐☐ High blood pressure
- ☐☐☐ Low blood pressure
- ☐☐☐ Pain over heart
- ☐☐☐ Poor circulation
- ☐☐☐ Rapid heart beat
- ☐☐☐ Slow heart beat
- ☐☐☐ Swelling of ankles

RESPIRATORY

- ☐☐☐ Chest pain
- ☐☐☐ Chronic cough
- ☐☐☐ Difficult breathing
- ☐☐☐ Spitting up blood
- ☐☐☐ Spitting up phlegm
- ☐☐☐ Wheezing

SKIN

- ☐☐☐ Boils
- ☐☐☐ Bruise easily
- ☐☐☐ Dryness
- ☐☐☐ Hives or allergy
- ☐☐☐ Itching
- ☐☐☐ Skin eruptions (rash)
- ☐☐☐ Varicose veins

GENITO-URINARY

- ☐☐☐ Bed-wetting
- ☐☐☐ Blood in urine
- ☐☐☐ Frequent urination
- ☐☐☐ Inability to control kidneys
- ☐☐☐ Kidney infection or stones
- ☐☐☐ Painful urination
- ☐☐☐ Prostate trouble
- ☐☐☐ Pus in urine

FOR WOMEN ONLY

- ☐☐☐ Congested breasts
- ☐☐☐ Cramps or backache
- ☐☐☐ Excessive menstrual flow
- ☐☐☐ Hot flashes
- ☐☐☐ Irregular cycle
- ☐☐☐ Lumps in breast
- ☐☐☐ Menopausal symptoms
- ☐☐☐ Painful menstruation
- ☐☐☐ Vaginal discharge

CHECK TILE FOLLOWING CONDITIONS YOU HAVE HAD:

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

Have you ever had previous Chiropractic care? yes no If yes, date of last visit _____

What was your response to prior chiropractic care? excellent good fair poor

Is your present condition being filed under Workmen's Compensation or No Fault? Yes No