

CONFIDENTIAL PATIENT CASE HISTORY



Dear Patient:

Please complete this questionnaire. Your answers will help us to 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 _____ Age _____ Birth Date _____ Marital Status: M S W D
Work Telephone _____ # Children _____ Spouse's Name _____
Cell Number _____ Email Address: _____
Occupation _____ Referred By _____ Sex: Male Female

HEALTH INFORMATION:

Have you had previous chiropractic care? _____ If yes, when? _____

1. What is your major complaint? _____

Other Complaints: _____

2. Where is the symptom? _____

3. When did the *symptom first* start? _____

Have you had this or similar conditions in the past? _____

4. How would you describe your pain? (check more than one if necessary to describe your problem)
 Sharp Dull Burning Numbness and Tingling Pressure Comes and Goes
 Constant Throbbing Travels Tearing Achy

5. When at it's worst rate the severity of your problem: Best 1 2 3 4 5 6 7 8 9 10 Worst

6. What activities aggravate your condition? _____

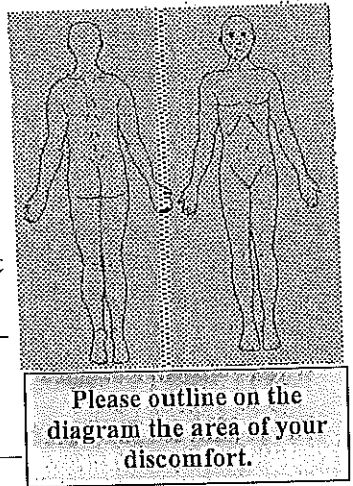
7. It interferes with: Work Sleep Walking Sitting Hobbies Leisure

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

9. Other doctors who treated this condition _____

10. List surgical operations and years: _____

11. Age of Mattress: _____ Comfortable Uncomfortable 12. Date of last physical exam: _____



Drugs you now take:

Pain Killers Nerve Pills Muscle Relaxers Insulin Hormones Tranquilizer Birth Control
 Mood Related Drugs Blood Pressure Medication Other _____

At our office we are not only interested in your well being, but also the health and well being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Mother/ father _____
Siblings _____
Others _____

FEMALE ONLY: Is there any chance that you may be pregnant? Yes No

Have you been in an auto accident? _____ Past Year _____ Past 5 years _____ Over 5 years _____ Never
Describe: _____

Have you had any personal injury or accident? _____ Past Year _____ Past 5 years _____ Over 5 years _____ None
Describe: _____

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

<u>Childhood Years</u>	Yes	No	Unsure	<u>Adult Years (18-present)</u>	Yes	No	Comments
Did you have any childhood illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do/Did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there a prolonged use of medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do/ Did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any falls from height Over 3 feet (i.e. crib, bunks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do/Did you play adult/extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/ use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Have you suffered from?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Numbness in fingers/hands | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Pins & Needles |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Cold Feet /Cold Hands |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Backaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Hip Pain / Thigh Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Sleep Disorders | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Ringing/Buzzing ears |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Pain Down Back or Leg | <input type="checkbox"/> Mood Swings /Depression |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Numbness in toes/feet | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hand/finger/wrist pain | <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Menstrual pain/irregular | <input type="checkbox"/> Other _____ |

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 Company _____ Policy # _____

Are you covered by Medicare? No Yes If yes, Health Insurance # _____

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 my account or 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, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____

Doctor's Signature: _____

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)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS