Confidential Patient Case History

Name_____ Date_____ Home Phone_____

Address_____ City_____ State_____ Zip_____ Work Phone_____

Date of Birth____/____/____ Age:_____ M ☐ F ☐ Marital Status [M] [S] [W] [D] CellPhone_____

Occupation_____ SS#_____ Emergency Contact_____ Phone_____

Referred By? Primary Doctor ☐ Family / Friend ☐ Advertising ☐ Other ☐ Name_____

THIS IS A CONFIDENTIAL HEALTH REPORT. Please check the appropriate box for any of the following syptoms which you now have or have had previously. **O- Occasional F-Frequent C-Constant**

O	F	C	GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Headache
☐	☐	☐	Loss of Sleep
☐	☐	☐	Loss of Weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot Trouble
☐	☐	☐	Lower Back Pain
☐	☐	☐	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

O	F	C	GASTRO-INTESTINAL
☐	☐	☐	Belching or Gas
☐	☐	☐	Colitis
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult Digestion
☐	☐	☐	Distension of Abdomen
☐	☐	☐	Excessive Hunger
☐	☐	☐	Gall Bladder Trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Hernia
☐	☐	☐	Jaundice
☐	☐	☐	Liver Trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over Stomach
☐	☐	☐	Poor Appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of Blood
			EYES, EARS, NOSE & THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear Discharge
☐	☐	☐	Ringing of Ears
☐	☐	☐	Enlarged Thyroid
☐	☐	☐	Eye Pain
☐	☐	☐	Vision Trouble not Improved by
☐	☐	☐	Glasses
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal Obstruction
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus Infection
☐	☐	☐	Sore Throat
☐	☐	☐	Tonsillitis

O	F	C	CARDIO-VASCULAR
☐	☐	☐	Hardening of Arteries
☐	☐	☐	High Blood Pressure
☐	☐	☐	Low Blood Pressure
☐	☐	☐	Poor Circulation
☐	☐	☐	Rapid Heart Beat
☐	☐	☐	Slow Heart Beat
☐	☐	☐	Swelling of Ankles
			RESPIRATORY
☐	☐	☐	Chest Pain
☐	☐	☐	Chronic Cough
☐	☐	☐	Difficulty Breathing
☐	☐	☐	Spitting up Blood
☐	☐	☐	Spitting up Pleghm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Acne
☐	☐	☐	Bruise Easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or Rash
☐	☐	☐	Itching
☐	☐	☐	Varicose-veins
			GENITAL-URINARY
☐	☐	☐	Bed-Wetting
☐	☐	☐	Blood in Urine
☐	☐	☐	Erectile Dysfunction
☐	☐	☐	Frequent Urination
☐	☐	☐	Kidney Infection or Stones
☐	☐	☐	Painful Urination
☐	☐	☐	Prostrate Trouble
			FOR WOMEN ONLY
☐	☐	☐	Breast Fullness
☐	☐	☐	Cramps or Backaches
☐	☐	☐	Excessive Menstural Flow
☐	☐	☐	Hot Flashes
☐	☐	☐	Irregular Cycle
☐	☐	☐	Menopausal Symptoms
☐	☐	☐	Vaginal Discharge
[Y]	[N]		Are you Pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD

☐ Alcoholism	☐ Cold Sores	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Venereal Disease
☐ Anemia	☐ Diabetes	☐ High Cholesterol	☐ Mumps	☐ Whooping Cough
☐ Appendicitis	☐ Eczema	☐ HIV / AIDS	☐ Pleurisy	
☐ Arteriosclerosis	☐ Emphysema	☐ Influenza	☐ Pneumonia	
☐ Arthritis	☐ Epilepsy	☐ Measles	☐ Stroke	
☐ Cancer	☐ Gout	☐ Miscarriage	☐ Ulcers	

Have you had chiropractic care in the past? [Y] [N] If Yes, Date of last care?_____

Do you have Health Insurance? [Y] [N] What Company?_____ Is this a Work-Comp Case? [Y] [N]

1. What is you major complaint? _____

Other complaints you would like to discuss or like more information about: _____

_____ Natural Health Care Approach? _____

2. When did the symptoms first start? _____

Have you had Previously? _____ When? _____

3. Describe your symptoms (check all that apply): ☐ Stiffness ☐ Weakness ☐ Sharp ☐ Dull ☐ Burning ☐ Tearing

☐ Numb/Tingling ☐ Pressure ☐ Throbbing ☐ Aching ☐ Sore ☐ Travels - Where? _____

☐ Constant ☐ Frequent ☐ Intermittent ☐ Rare

4. Pain at it's worst? --1----------5----------10—

5. What activities aggravate your problem? (check all that apply):

☐ Sitting ☐ Standing ☐ Half-bend forward

☐ Full-bend forward ☐ Transition - sit to stand

☐ Bend backward ☐ Look up ☐ Look down

☐ Turning L or R ☐ Walk up steps ☐ Walk down steps

☐ Lifting – How much weight? _____

☐ Walk – How far? (in blocks) _____

☐ Leisure activities (golf, bowl, run) _____

☐ Daily activities (dishes, vacuum, laundry) _____

☐ Personal activities (dress, bathe, sex) _____

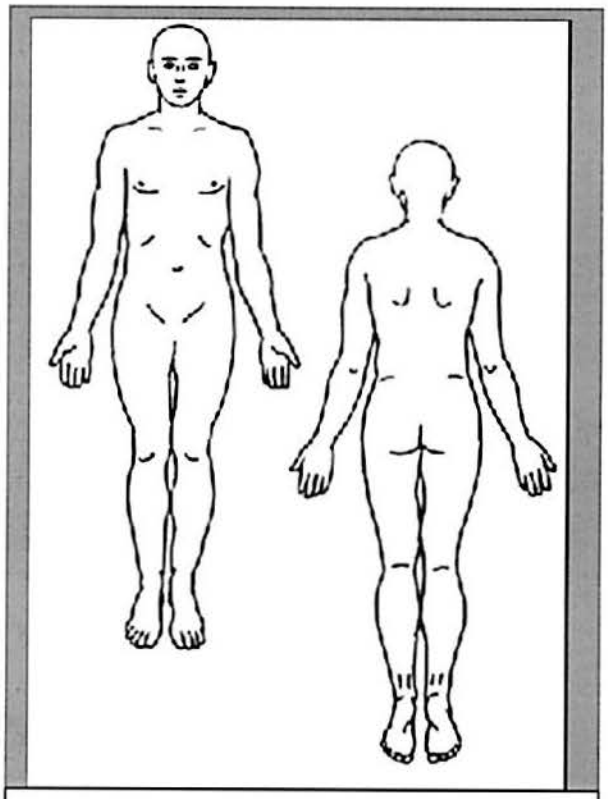
6. What provides relief? ☐ Sit ☐ Stand ☐ Lean ☐ Walk

☐ Half-bend ☐ Full-bend ☐ Stretch ☐ Exercise ☐ Sleep

☐ Moving around ☐ Lying down ☐ Massage ☐ Chiropractic care

☐ OTC (Advil, Aleve, Tylenol) ☐ Prescription pain relievers

☐ Heat ☐ Ice



Please outline on the diagram the area of your discomfort

7. Since your problem started, has it gotten worse? ☐ Y ☐ N

8. Please list any other doctors consulted for this problem: _____

May we contact them? ☐ Y ☐ N

9. Do you have a family physician? ☐ Y ☐ N May we contact them? ☐ Y ☐ N Contact Info: _____

10. Is this condition a result of an accident, sports injury, work injury? ☐ Y ☐ N

Please describe: _____

11. Have you missed any work due to your problem? ☐ Y ☐ N

Past Health History

Have you been in an auto accident? Past year_____ Past 5 years_____Over 5 years_____Never_____

Have you been injured at work? Past year_____Past 5 years_____Over 5 years_____Never_____

Surgical History

Dates_____ Condition_____

Dates_____ Condition_____

Dates_____ Condition_____

Dates_____ Condition_____

Dates_____ Condition_____

Dates_____ Condition_____

Dates_____ Condition_____

Dates_____ Condition_____

Employment Status

Full Time _____ Part Time _____Student Full Time_____ Student Part Time_____ Retired_____

Race

White_____ Black/African American_____ Hispanic_____ American Indian_____ Alaskan Native_____

Japanese_____ Korean_____ Chinese_____ Vietnamese_____ Filipino_____ Other_____

I choose not to specify_____

Multi-Racial (check one)

Yes_____ No_____

Ethnicity

Hispanic or Latino_____ Not Hispanic or Latino_____ I choose not to specifiy_____

Preferred Language

English_____ Spanish_____ Sign Language_____

Preferred Method Of Contact

Telephone_____ E-Mail_____

Verification (for e-mail)

Choose only one question.....

Verification Answer

Personal History

Do you currently use tobacco products

Yes_____ No_____

Type

Chew_____ Cigar_____ Cigarette_____ Vaping_____

Frequency of use_____ number and frequency

Do you currently use alcohol

Yes_____ No_____

Frequency

Daily_____ Several times a week_____ Once a week_____ Less than once a week

Do you use caffeine

Yes_____ No_____

Frequency of use _____ number and frequency

Do you exercise

Yes_____ No_____

Frequency

Daily_____ Several times a week_____ Once a week_____ Less than once a week

Do you use OTC pain relievers

Yes_____ No_____

Please rate your sleep quality 1(bad)_____10(good)

Number of hours sleep per day_____

Medications

Please provide a current list of medications, why they are being prescribed and by whom.

If there are no current medications, check here_____

Please provide a list of any known allergies you have had to medications.

If no allergies are known, please check here_____

Family Health History

Name	Relation	Past/Present Health Problems