Confidential Patient Case History

NAME_____ SOCIAL SECURITY #_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

WORK TELEPHONE_____ AGE_____ BIRTHDATE_____ MARITAL STATUS: M S W D

HOME TELEPHONE_____CELL PHONE_____ EMAIL ADDRESS_____

CHILDREN_____ CONTACT NAME_____ CONTACT TELEPHONE_____

OCCUPATION_____REFERRED BY_____

HEALTH INFORMATION: Have you had previous chiropractic care?_____

What is your chief complaint?_____

_____

Other complaints:_____

How long have you had this condition?_____ Have you had this or a similar condition in the past?_____

What aggravates your condition:?_____

Is the condition getting progressively worse? Yes_____ No_____ Constant_____ Comes and goes _____

Please rate the intensity of your condition: (absent) 0 1 2 3 4 5 6 7 8 9 10 (intense)

Please estimate the percentage of time you are affected: ___ 0-25% ____26-50% _____51-75% ____76-100%

Is this condition affecting your: _____Work _____Sleep ____Daily Routine ____Other_____

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

Other **doctors** who have treated you for this condition:_____

_____

Please list **surgical** operations and years:_____

_____

Drugs you now take:_____

Age of **mattress**: _____ Comfortable_____ Uncomfortable_____

Are you wearing: _____Heel lifts _____ Inner soles _____Orthotics _____ Arch supports

Have you had any **personal injury or accident**? ___Past year ___Past 5 years ____Over 5 years ___Never

Describe:_____

Have you ever suffered a **head trauma or concussion**? Describe:_____

Date of last physical? _____ Height: _____ Weight:_____

Family health: mother_____ father _____ siblings_____

Do you eat, drink, or use: _____Alcohol _____Coffee _____Tea _____Cigarettes _____Sugar

Which, if any, vitamins do you take? _____

- O = Occasional
- F = Frequent
- C = Constant

Gastro-Intestinal
___Nausea
___Vomiting food
___Vomiting blood
___Abdominal pain
___Poor appetite
___Excessive hunger
___Difficulty chewing
___difficulty swallowing
___Excessive thirst
___Diarrhea
___Constipation
___Bloody stool
___Colitis
___Hemorrhoids
___Weight trouble
___Weight gain
___Weight loss
___Liver trouble
___Gallbladder trouble

Nervous System
___Insomnia
___Dizziness
___Fainting
___Numbness
___Loss of feeling
___Paralysis
___Headaches
___Convulsions
___Muscle spasms
___Confusion
___Depression

Cardio-Vascular
___Chest pain
___Rapid heartbeat
___Heart problems
___Pain over heart
___Blood pressure problems
___Varicose veins
___Lung problems
___Coughing phlegm
___Coughing blood
___Persistent cough
___Difficult breathing

Eye, Ear, Nose and Throat
___Allergy
___Asthma
___Eye strain
___Vision problems
___Eye infection
___Hearing loss
___Ear noises
___Ear pain
___Ear discharge
___Nose bleeding
___Nose discharge
___Nose pain
___Difficult nose breathing
___Difficult speech
___Dental problems
___Sore gums
___Sore mouth
___Sore throat
___Hoarseness

Genito-Urinary
___Bladder trouble
___Painful urination
___Discolored urine
___Scanty urine
___Excessive urine

Female
___Vaginal discharge
___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breast
Are you pregnant?
___yes ___no

Musculo-Skeletal
___Low back problems
___Neck problems
___Pain between shoulders
___Arm problems
___Leg problems
___Painful joints
___Stiff joints
___Swollen joints
___Sore muscles
___Weak muscles
___Broken bone
___Walking problems