

Confidential Patient Case History

Dear Patient: 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 _____ DATE _____ HOME PHONE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ WORK PHONE _____
 DATE OF BIRTH _____ AGE _____ M _____ F _____ MARITAL STATUS _____ NO. CHILDREN _____
 OCCUPATION _____ SS # _____ SPOUSE _____
 WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O - OCCASIONAL
 F - FREQUENT
 C - CONSTANT

O F C

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

O F C

GASTRO-INTESTINAL

- 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
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

O F C

CARDIO-VASCULAR

- 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
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

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

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____

Is this an Industrial Accident Case? Yes No