

# CONFIDENTIAL 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. PLEASE PRINT, THANK YOU

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PHONE \_\_\_\_\_ (WORK) \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ SS # \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
SPOUSE \_\_\_\_\_ REFERRED BY \_\_\_\_\_  
SPOUSE'S OCCUPATION \_\_\_\_\_ SPOUSE'S EMPLOYER \_\_\_\_\_  
CHILDREN \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  
PLEASE DESCRIBE YOUR MAJOR COMPLAINTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LOCATION OF PAIN? \_\_\_\_\_

IS THIS A RESULT OF A SPECIFIC INCIDENT (EXPLAIN) \_\_\_\_\_

WHEN DID IT START? \_\_\_\_\_ HAVE YOU EVER HAD THIS CONDITION BEFORE  YES  NO

IF YES, PLEASE DESCRIBE: \_\_\_\_\_

WHAT ACTIVITIES MAKE IT WORSE? \_\_\_\_\_

IS THIS CONDITION GETTING WORSE?  YES  NO  CONSTANT  COMES AND GOES

DOES THIS CONDITION INTERFERE WITH:  WORK  SLEEP  DAILY ACTIVITY  OTHER \_\_\_\_\_

IS THIS CONDITION DUE TO:  PERSONAL INJURY  ON - THE - JOB INJURY  AUTO ACCIDENT

HAVE YOU DONE ANYTHING TO TREAT THIS CONDITION YOURSELF? \_\_\_\_\_

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION?  YES  NO THEIR NAMES \_\_\_\_\_

HIS DIAGNOSIS \_\_\_\_\_

RESULTS:  GOOD  FAIR  POOR  NONE

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.

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|-----------------------------------------------|------------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> NECK PAIN            | <input type="checkbox"/> BURSITIS              | <input type="checkbox"/> TONSILLITIS          | <input type="checkbox"/> LUMPS IN BREAST    |
| <input type="checkbox"/> NECK STIFFNESS       | <input type="checkbox"/> HERNIA                | <input type="checkbox"/> HAY FEVER            | CONDITIONS:                                 |
| <input type="checkbox"/> NECK GRATING         | <input type="checkbox"/> PINCHED NERVES        | <input type="checkbox"/> SORE THROATS         | <input type="checkbox"/> COLDS              |
| <input type="checkbox"/> NECK TENSION         | <input type="checkbox"/> HEADACHES             | <input type="checkbox"/> EYE PAIN             | <input type="checkbox"/> FLU                |
| <input type="checkbox"/> MID - BACK PAIN      | <input type="checkbox"/> MIGRAINES             | <input type="checkbox"/> FAILING VISION       | <input type="checkbox"/> ALCOHOLISM         |
| <input type="checkbox"/> MID - BACK STIFFNESS | <input type="checkbox"/> DIZZINESS             | <input type="checkbox"/> EAR TROUBLES         | <input type="checkbox"/> ANEMIA             |
| <input type="checkbox"/> MID - BACK GRATING   | <input type="checkbox"/> FAINTING              | <input type="checkbox"/> RINGING IN THE EARS  | <input type="checkbox"/> ARTERIOSCLEROSIS   |
| <input type="checkbox"/> MID - BACK TENSION   | <input type="checkbox"/> FATIGUE               | <input type="checkbox"/> NOSE BLEEDS          | <input type="checkbox"/> ARTHRITIS          |
| <input type="checkbox"/> LOW BACK PAIN        | <input type="checkbox"/> NERVOUSNESS           | <input type="checkbox"/> HIGH BLOOD PRESSURE  | <input type="checkbox"/> CANCER             |
| <input type="checkbox"/> LOW BACK STIFFNESS   | <input type="checkbox"/> DEPRESSION            | <input type="checkbox"/> LOW BLOOD PRESSURE   | <input type="checkbox"/> CROUP              |
| <input type="checkbox"/> LOW BACK GRATING     | <input type="checkbox"/> CONVULSIONS           | <input type="checkbox"/> CHEST PAINS          | <input type="checkbox"/> DIABETES           |
| <input type="checkbox"/> LOW BACK TENSION     | <input type="checkbox"/> BAD MOODS & BEHAVIOUR | <input type="checkbox"/> POOR CIRCULATION     | <input type="checkbox"/> EPILEPSY           |
| PAIN IN:                                      | <input type="checkbox"/> TREMORS               | <input type="checkbox"/> CHRONIC COUGH        | <input type="checkbox"/> HEART DISEASE      |
| <input type="checkbox"/> SHOULDERS            | <input type="checkbox"/> INSOMNIA              | <input type="checkbox"/> DIFFICULT BREATHING  | <input type="checkbox"/> MISCARRIAGE        |
| <input type="checkbox"/> ARMS                 | <input type="checkbox"/> SWEATS                | <input type="checkbox"/> SKIN ERRUPTIONS      | <input type="checkbox"/> MULTIPLE SCLEROSIS |
| <input type="checkbox"/> HANDS                | <input type="checkbox"/> CHILLS                | <input type="checkbox"/> VARICOSE VEINS       | <input type="checkbox"/> PNEUMONIA          |
| <input type="checkbox"/> HIPS                 | <input type="checkbox"/> BELCHING/GAS          | <input type="checkbox"/> ACNE                 | <input type="checkbox"/> POLIO              |
| <input type="checkbox"/> LEGS                 | <input type="checkbox"/> COLON TROUBLE         | <input type="checkbox"/> BOILS                | <input type="checkbox"/> STROKE             |
| <input type="checkbox"/> FEET                 | <input type="checkbox"/> CONSTIPATION          | <input type="checkbox"/> ITCHING              | <input type="checkbox"/> T.B.               |
| NUMBNESS IN:                                  | <input type="checkbox"/> DIARRHEA              | <input type="checkbox"/> BED WETTING          | <input type="checkbox"/> ULCERS             |
| <input type="checkbox"/> SHOULDERS            | <input type="checkbox"/> INDIGESTION           | <input type="checkbox"/> BLOOD IN URINE       | <input type="checkbox"/> MENTAL DISORDERS   |
| <input type="checkbox"/> ARMS                 | <input type="checkbox"/> HEMORROIDS            | <input type="checkbox"/> FREQUENT URINATION   | <input type="checkbox"/> OTHER _____        |
| <input type="checkbox"/> HANDS                | <input type="checkbox"/> NAUSEA                | <input type="checkbox"/> PAINFUL URINATION    | _____                                       |
| <input type="checkbox"/> HIPS                 | <input type="checkbox"/> GALL BLADDER TROUBLE  | <input type="checkbox"/> KIDNEY TROUBLE       | _____                                       |
| <input type="checkbox"/> LEGS                 | <input type="checkbox"/> LIVER TROUBLE         | <input type="checkbox"/> PROSTATE TROUBLE     | _____                                       |
| <input type="checkbox"/> FEET                 | <input type="checkbox"/> VOMITING              | <input type="checkbox"/> MENSTRUAL CRAMPS     | _____                                       |
| <input type="checkbox"/> PAINFUL TAIL BONE    | <input type="checkbox"/> STOMACH ACHES         | <input type="checkbox"/> EXCESSIVE FLOW       | _____                                       |
| <input type="checkbox"/> SCIATICA             | <input type="checkbox"/> ASTHMA                | <input type="checkbox"/> IRREGULAR CYCLE      | _____                                       |
| <input type="checkbox"/> PAINFUL JOINTS       | <input type="checkbox"/> ALLERGIES             | <input type="checkbox"/> ARE YOU PREGNANT     | _____                                       |
| <input type="checkbox"/> SWOLLEN JOINTS       | <input type="checkbox"/> SINUS                 | <input type="checkbox"/> MENAPAUASAL SYMPTOMS | _____                                       |

FAMILY HISTORY: \_\_\_\_\_

OTHER COMPLAINTS OR COMMENTS: \_\_\_\_\_

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT OR OTHER SERIOUS INJURIES?  YES  NO IF YES, PLEASE DESCRIBE \_\_\_\_\_

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HAVE YOU EVER HAD SURGERY?  YES  NO IF YES, PLEASE DESCRIBE \_\_\_\_\_

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ARE YOU NOW TAKING ANY PRESCRIPTION OR NON - PRESCRIPTION DRUGS OR MEDICATION?  YES  NO IF YES, PLEASE GIVE NAMES \_\_\_\_\_

HAVE YOU EVER HAD A FRACTURED BONE?  YES  NO IF YES, PLEASE DESCRIBE \_\_\_\_\_

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HAVE YOU EVER BEEN HOSPITALIZED  YES  NO IF YES, PLEASE DESCRIBE \_\_\_\_\_

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HAVE YOU EVER BEEN TREATED FOR ANY OTHER HEALTH CONDITION IN THE PAST YEAR?  YES  NO IF YES, PLEASE DESCRIBE: \_\_\_\_\_

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HAVE YOU BEEN UNDER CHIROPRACTIC CARE BEFORE?  YES  NO NAME OF DOCTOR \_\_\_\_\_

DATE OF LAST ADJUSTMENT \_\_\_\_\_ RESULTS \_\_\_\_\_

I DO HEREBY CERTIFY, THAT ALL OF MY STATEMENTS ON THIS APPLICATION FOR CHIROPRACTIC CARE ARE TRUE, ACCURATE AND COMPLETE.

YOUR SIGNATURE \_\_\_\_\_