# Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU

**Name:** ______________________ **Date:** ______________

**Address:** ______________________ **City:** ____________ **State:** ______ **Zip:** ________

**Home Phone:** ______________ **Cell:** ______________ **Work:** ______________

**Date of Birth:** __________ **Age:** ______ **M** ____ **F** ____ **Marital Status:** ________ **# Of Children** ________

**Occupation:** ______________ **SS#** ______________ **Spouse's Name:** ______________

**Email:** ______________________ **Referred By:** ______________________

**Primary Care Physician:** ______________ **Phone #/Address:** ______________________

---

Please circle the appropriate response 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-OCASSIONAL**
**F-FREQUENT**
**C-CONSTANT**

O F C

**GENERAL**

- O F C ALLERGY
- O F C CHILLS
- O F C CONVULSIONS
- O F C DIZZINESS
- O F C FAINTING
- O F C FATIGUE
- O F C FEVER
- O F C HEADACHE
- O F C LOSS OF WEIGHT
- O F C NERVOUSNESS/DEPRESSION
- O F C NEURALGIA
- O F C NUMBNESS
- O F C SWEATS
- O F C TREMORS

**MUSCLE & JOINT**

- O F C ARTHRITIS
- O F C BURSITIS
- O F C FOOT TROUBLE
- O F C HERNIA
- O F C LOW BACK PAIN
- O F C LUMBAGO
- O F C NECK PAIN OR STIFFNESS
- O F C PAIN BETWEEN SHOULDERS

**PAIN OR NUMBNESS IN:**

- O F C ARMS
- O F C ELBOWS
- O F C HANDS
- O F C HIPS
- O F C LEGS
- O F C KNEES
- O F C FEET
- O F C PAINFUL TAILBONE
- O F C SPINAL CURVITURE
- O F C SWOLLEN JOINTS

O F C

**GASTRO-INTESTINAL**

- O F C BELCHING OR GAS
- O F C COLITIS
- O F C COLON TROUBLE
- O F C CONSTIPATION
- O F C DIARRHEA
- O F C DIFFICULTY DIGESTION
- O F C DISTENSION OF ABDOMEN
- O F C EXCESSIVE HUNGER
- O F C GALL BLADDER TROUBLE
- O F C HEMORRHOIDS
- O F C INTESTINAL WORMS
- O F C JAUNDICE
- O F C LIVER TROUBLE
- O F C NAUSEA
- O F C POOR APPETITE
- O F C VOMITING
- O F C VOMITING OF BLOOD

**EYES, EARS NOSE & THROAT**

- O F C ASTHMA
- O F C COLDS
- O F C CROSSED EYES
- O F C DEAFNESS
- O F C DENTAL DECAY
- O F C EARACHE
- O F C EAR DISCHARGE
- O F C EAR NOISES
- O F C ENLARGED GLANDS
- O F C ENLARGED THYROID
- O F C FAILING VISION
- O F C FAR SIGHTEDNESS
- O F C GUM TROUBLE
- O F C HAY FEVER
- O F C HOARSENESS
- O F C NASAL OBSTRUCTION
- O F C NEAR SIGHTEDNESS
- O F C NOSEBLEEDS
- O F C SINUS INFECTION

O F C

**CARDIO- VASCULAR**

- O F C HARDENING OF ARTERIES
- O F C HIGH BLOOD PRESSURE
- O F C LOW BLOOD PRESSURE
- O F C PAIN OVER HEART
- O F C POOR CIRCULATION
- O F C RAPID HEART BEAT
- O F C SLOW HEART BEAT
- O F C SWELLING OF ANKLES

**RESPIRATORY**

- O F C CHEST PAIN
- O F C CHRONIC COUGH
- O F C DIFFICULTY BREATHING
- O F C SPITTING UP BLOOD
- O F C SPITTING UP PHLEGM

**SKIN**

- O F C BOILS
- O F C BRUISE EASILY
- O F C DRYNESS
- O F C HIVES OR ALLERGY
- O F C ITCHING
- O F C SKIN ERRUPTIONS (RASH)
- O F C VARICOSE VEINS

**GENITO-URINARY**

- O F C BED-WETTING
- O F C BLOOD IN URINE
- O F C FREQUENT URINATION
- O F C INABILITY TO CONTROL KIDNEYS
- O F C KIDNEY INFECTION OR STONES
- O F C PAINFUL URINATION
- O F C PUS IN URINE

**FOR WOMEN ONLY**

- O F C CONGESTED BREASTS
- O F C CRAMPS OR BACKAHES
- O F C EXCESSIVE MENSTRUAL FLOW
- O F C HOT FLASHES
- O F C IRREGULAR CYCLE
- O F C MENOPAUSAL SYMPTOMS

YES__NO__ ARE YOU PREGNANT?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD**

— ALCOHOLISM
— ANEMIA
— APPENDICITIS
— ARTERIOSCLEROSIS
— ARTHRITIS
— CANCER
— CHOREA
— COLD SORES
— DIABETES
— DIPHTHERIA
— ECZEMA
— EMPHYSEMA
— EPILEPSY
— FEVER BLISTERS
— GOITER
— GOUT
— HEART DISEASE
— INFLUENZA
— LUMBAGO
— MALARIA
— MEASLES
— MISCARRIAGE
— MULTIPLE SCLEROSIS
— MUMPS
— PLEURISY
— PNEUMONIA
— POLIO
— RHEUMATIC FEVER
— SCARLET FEVER
— STROKE
— TUBERCULOSIS
— TYPHOID FEVER
— ULCERS
— VENEREAL DISEASE
— WHOOPING COUGH

HAVE YOU EVER HAD 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___