

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.
THANK YOU.

Name _____ Birthday _____ Sex M F

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Home # _____ Work # _____ E-Mail _____

Occupation _____ Employer _____

Marital Status M S D W Spouse's Name _____ Children, Ages _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Does anything make it feel worse? _____

Does anything make it feel better? _____

Is this condition: Improved Unchanged Getting Worse

Is this condition interfering with your: Work Sleep Daily Routine Other _____

Other doctors or therapists who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

Have you ever been to a Chiropractor before? If yes, when? _____

Do you have a family physician? Name _____

Medications, dosage and frequency: _____

Have you been in an auto accident or had any other personal injury? Yes No Describe _____

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name _____ Number _____ Date _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

GENERAL **NOW** **PAST**

- Weakness
- Fatigue
- Fever
- Chills
- Night Sweats
- Fainting

SKIN

- Color Changes
- Nail Changes
- Hair Changes
- Moles
- Rashes
- Sores
- Weakness

HEAD

- Headaches
- Injuries
- Bumps
- Last Eye Exam
- Glasses
- Contacts
- Cataracts

EARS

- Hard of Hearing
- Deafness
- Ringing
- Discharge
- Earache
- Itching
- Dizziness
- Room Spins

NOSE

- Decreased Smell
- Bleeding
- Pain
- Discharge
- Obstruction
- Post Nasal Drip
- Deviated Septum
- Runny Nose
- Sinus Congestion

MOUTH

- Bleeding Gums
- Sores
- Dental Problems
- Bad Breath
- Loss of Taste
- Dry Mouth
- Ulcers
- Blisters

THROAT **NOW** **PAST**

- Soreness
- Bad Tonsils
- Hoarseness
- Pain
- Trouble Swallowing
- Recurrent Infections

NECK

- Neck Enlargement
- Stiff Neck
- Soreness
- Lumps
- Masses

BREASTS

- Discharge
- Lumps
- Pain
- Bleeding
- Nipple Changes
- Skin Changes
- Bloated

LUNGS

- Cough
- Phlegm
- Blood
- Short of Breath
- Wheezing
- Pain
- Congestion
- Inhalant Exposure

HEART

- Murmur
- Palpitations
- Rapid Heartbeat
- Swollen Extremities
- Cold Extremities
- Chest Pain/Pressure
- Varicose Veins
- Blood Clots
- Blue Extremities

BLOOD

- Anemia
- Low Blood Iron
- Easy Bruising
- Easy Bleeding
- Swollen Nodes
- Painful Nodes
- Sugar in Blood
- Red Spots

GASTROINTESTINAL **NOW** **PAST**

- Abdominal Pain
- Nausea
- Bloated
- Belching
- Heartburn
- Indigestion
- Irregular Bowel Habits
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Poor Appetite
- Food Intolerance
- Bloody Stools
- Black Stools

GENITOURINARY

- Urgency
- Incontinence
- Straining
- Back Pain
- Frequent Voiding
- Stones
- Burning
- Bed Wetting
- Small Stream
- Discharge
- Impotence
- Dribbling
- Cloudy Urine
- Urine Color _____
- Spotting Between _____
- Periods
- Menstrual Cramps
- Discharge
- Itching
- Painful Intercourse
- Irregular Periods
- Hot Flashes
- Contraception Type _____
- Age at First Period _____
- Duration of Cycle _____
- Duration of Flow _____
- No. of Pregnancies _____
- No. of Births _____
- No. of Miscarriages _____
- No. of Abortions _____
- Menstrual Flow Heavy Mod Light
- Last Period _____
- Last Pap Smear _____
- Last Vaginal Exam _____
- Last Mammogram _____
- Last Prostate Exam _____

NAME _____

Patient Name _____ Number _____ Date _____ 2

NEUROLOGIC NOW PAST

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

ENDOCRINE

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

IMMUNIZATION/VACCINATION

- DPT
- Mumps
- Smallpox
- Thyroid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

BLOOD TYPE

- A + A -
- B + B -
- AB + AB -
- O + O -
- Other _____

BLOOD TRANSFUSIONS

- Date _____
- Date _____
- Date _____
- Date _____

PSYCHIATRIC NOW PAST

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

- | | |
|--|--|
| Hay Fever <input type="checkbox"/> | Epilepsy <input type="checkbox"/> |
| Mumps <input type="checkbox"/> | Paralysis <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Allergies <input type="checkbox"/> | Mental Illness <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Alcoholism <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Tumor <input type="checkbox"/> | Nervous Breakdown <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Migraine <input type="checkbox"/> |
| Leukemia <input type="checkbox"/> | Gout <input type="checkbox"/> |
| Heart Trouble <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/> |
| Varicose Veins <input type="checkbox"/> | Prostate Problems <input type="checkbox"/> |
| Phlebitis <input type="checkbox"/> | Sexual Problems <input type="checkbox"/> |
| Hypertension <input type="checkbox"/> | Gonorrhea <input type="checkbox"/> |
| Stroke <input type="checkbox"/> | Syphilis <input type="checkbox"/> |
| Ulcers <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Jaundice <input type="checkbox"/> | Bladder Trouble <input type="checkbox"/> |
| Skin Trouble <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> |
| Gallstones <input type="checkbox"/> | Kidney Infections <input type="checkbox"/> |
| Liver Trouble <input type="checkbox"/> | |
| Hepatitis <input type="checkbox"/> | |
| Parasites <input type="checkbox"/> | |

Date of Last Chest X-Ray _____ Normal Abnormal

Last TB Skin Test _____ Normal Abnormal

Allergies: _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per week _____ Type _____

Smoking Current Previous Packs/Day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine Cups/Day _____ No. of Years _____
(Coffee, Tea, Cola)

Aspirin No./Day _____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles Stabbing ////

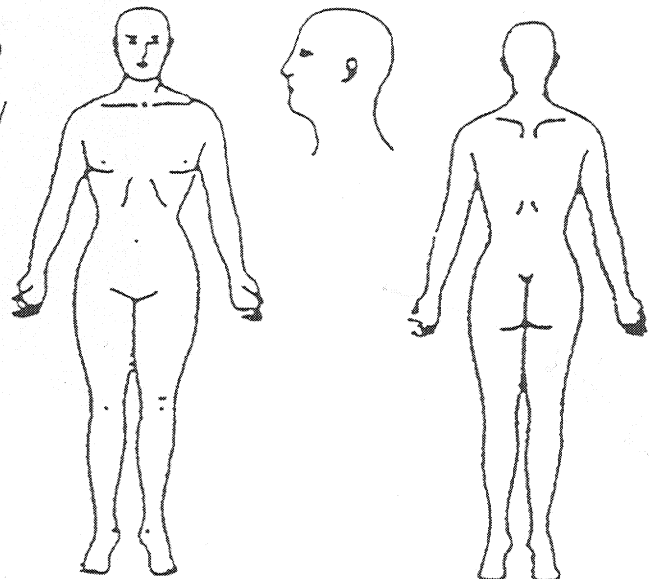
MARK AN "X" ON THE LINES:

How bad are your symptoms now?

_____ None _____ Most Severe

How bad have they been in the past?

_____ None _____ Most Severe



Patient Name _____ Number _____ Date _____ 4