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 ..... MOBILE PHONE ..... HOME PHONE .....

ADDRESS ..... EMAIL ..... WORK PHONE .....

DATE OF BIRTH..... AGE ..... M ..... F..... MARITAL STATUS ..... No. OF CHILDREN .....

OCCUPATION ..... REFERRED BY .....

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

OCCASIONAL	FREQUENT	CONSTANT	
			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:
☐	☐	☐	Shoulder
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diahhorea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of the abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall-bladder trouble
☐	☐	☐	Hemmorhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomitting
☐	☐	☐	Vomitting 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
☐	☐	☐	Hoarsness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsilitis

			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
☐	☐	☐	Prostrate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flushes
☐	☐	☐	Irregular cycle
☐	☐	☐	Lumps in breast
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple Scleriosis	☐ Stroke
☐ Appendicitis	☐ Diptheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid Fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal Disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic Fever	☐ 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

(Please complete other side)

What is your major complaint?.....

.....

Other complaints.....

How long have you had this condition? ..... Have you had this or similar conditions in the past? .....

What activities aggravate your condition? .....

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine Other.....

How long has it been since you really felt good? .....

What do you believe is wrong with you? .....

List surgical operations and years: .....

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquillisers
☐ Insulin ☐ Birth control pills Others.....

Dental visits: ☐ Every 6 months ☐ Yearly ☐ Toothache or "emergency" only ☐ Complete dentures

Age of mattress..... ☐ Comfortable ☐ Uncomfortable Do you use a bed board?.....

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you ever been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe.....

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe.....

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? .....

Have others in your family had such disorders ☐ Yes ☐ No When?.....

HAVE YOU EVER:	YES	NO
Been knocked unconscious?	☐	☐
Used a cane, crutch, or other support?	☐	☐
Been treated for a spine or nerve disorder?	☐	☐
Had a fractured bone?	☐	☐
Been hospitalised for other than surgery?	☐	☐

DO YOU	YES	NO
Now take vitamins or minerals?	☐	☐
Think you may need vitamins or minerals	☐	☐
Have an allergy to any drug?	☐	☐

DATE OF LAST

Spinal examination _____

Physical examination _____

Blood test _____

Chest X-Ray _____

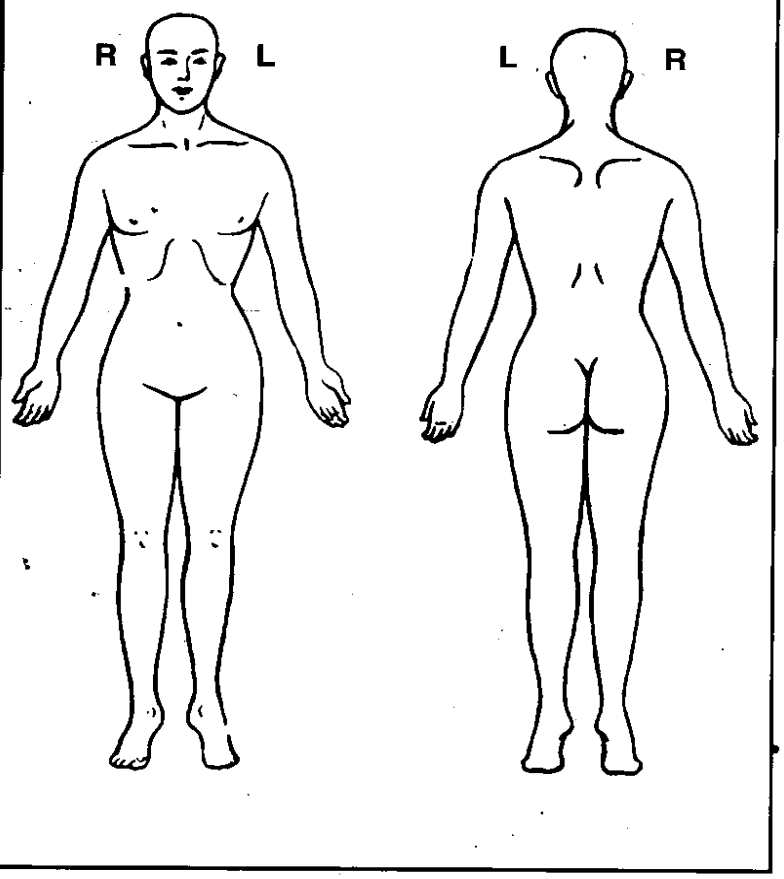
Spinal X-ray _____

Dental X-ray _____

Urine test _____

HABITS	YES	NO
Alcohol	☐	☐
Coffee	☐	☐
Tobacco	☐	☐
Drugs	☐	☐
Exercise	☐	☐
Sleep	☐	☐
Appetite	☐	☐

Please indicate position of pain or injury.



IN CASE OF EMERGENCY: (name of relative or close friend not living in your home):

Name ..... Phone .....

Address .....

Patients Signature ..... Date.....