CONFIDENTIAL PATIENT CASE HISTORY

Date:_____

Health and Healing Through Chiropractic

To our valued new patient, Thank you for choosing us to care for your chiropractic needs. We appreciate your confidence in our ability. In order to provide you with the quality chiropractic care that you deserve, please complete this questionnaire. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name _____ Social Security # _____ Sex: ☐Male ☐Female

Address _____ City_____State ___ Zip _____ Marital Status:☐M☐S☐W☐D

Home Phone _____Work # _____Cell # _____ Age_____ Birth date _____

Employer _____Occupation _____email _____

Spouse's Name: _____Spouses Birth date: _____ Spouses Work # _____

In case of emergency: (Name of relative or close friend, not living in your home):

Name:_____ relationship to you _____

Address: _____ phone _____

Who is responsible for this account? _____

Referred by_____Is it ok to send them a thank you note ( ) yes or ( ) no

Personal History and Habits

• Is your condition due to a current auto accident or job related injury? ☐Yes ☐No **If YES, please inform the receptionist immediately.**

• Have you been in an auto accident in the: ☐Past year ☐Past five years ☐Over five years ☐Never

Describe _____

• Have you had previous chiropractic care?_____ Name of the doctor who treated you:_____

• Do you take nutritional suppliments ?☐Yes ☐No • Would you like information on supplements? ☐Yes ☐No

• RX DRUGS: (Check all that apply)

☐Nerve pills ☐Pain killers ☐Muscle relaxers ☐Pep pills ☐Tranquilizers ☐Birth Control Pills ☐Asprin ☐Ibuprophen

Others_____

• Dental Visits: ☐Every six months ☐Yearly ☐Toothache or Emergency visits only ☐ Complete dentures

• Do you use arch supports? ☐No ☐Heel Lifts ☐Sole Lifts ☐Inner Soles ☐Negative Heels ☐Platform Shoes

• Age of your mattress:_____ • Is it comfortable? ☐Yes ☐No • Do you use a bed board? ☐Yes ☐No

HAVE YOU EVER:	YES	NO	**If yes, explain:**
Had a broken bone?			
Been hospitalized?			
Had strains or sprains?			
Used a cane, crutch or other support?			
Been struck unconscious?			
Been hospitalized other then for surgery?			
DO YOU:	Yes	No	**What?**
Have any drug allergy?			
WHEN WAS YOUR LAST:	Yes	No	**When?**
Spinal X-ray			
Spinal examination			
Physical examination			

HABITS	
Alcohol–How many drinks per week?	
Coffee – How many cups per day?	
Tobacco – Do you use?	YES NO
Drugs	YES NO
Exercise - How many times a week?	
Sleep – How many hours per day?	
Do you wake up feeling rested?	YES NO
Appetite	GOOD or NOT MUCH
Soft Drinks – How many per day?	
Salty foods	YES or NOT MUCH
Water – How many oz. per day? (1/2 body weight in oz. per day is normal)	OZ.
Sugar products	YES or NOT MUCH
Artificial sweeteners– How much?	

Please **TURN OVER** and answer questions on the back .

• Please supply the name of your current physician Dr._____ Specialist?_____

• Please list all of your health conditions and surgeries including the year they occurred. (Example: high blood pressure-1998, Diabetes-genetic, pacemaker-1980 etc…) _____

_____

_____

_____

Family Health Information

Health conditions: Ex: Diabetes, High Blood Pressure, Cancer, Stroke. ***Some health conditions are the result of hereditary spinal weaknesses or other weaknesses. Information about your immediate family members: brothers, sisters, parents, grandparents, will give us a better understanding of your total health picture.***

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Current Condition(s)

• What is your major complaint?_____Other complaints_____

• How long have you had this condition?_____ • How long has it been since you really felt good?_____

• What do you believe is wrong with you? _____

• Have you had this or similar conditions in the past? ☐Yes ☐No If Yes, explain? _____

• List previous diagnoses and treatments you have received for present condition? _____

• What activities aggravate your condition? ☐Standing ☐Sitting ☐Walking ☐Other_____

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

• Does your condition interfere with any of the following: ☐Work ☐Sleep ☐Daily routine ☐Other_____

• Have you missed days at work or school? ☐Yes ☐No

• Is the Pain worse in the ☐Am or ☐Pm? • Does pain wake you at night? ☐Yes ☐No

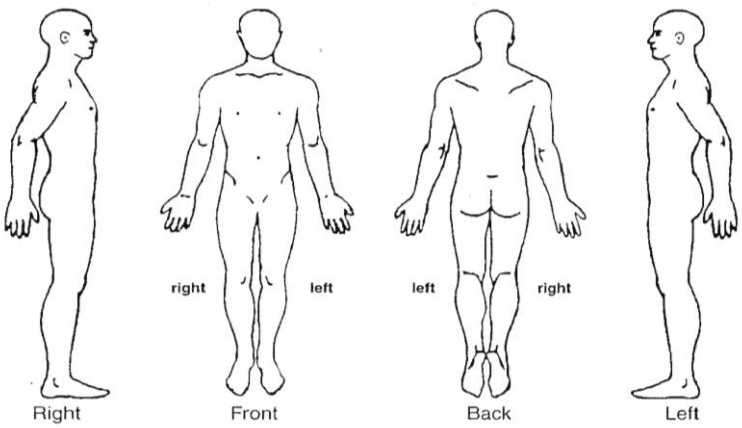
• How is most of your day spent? ☐Standing ☐Sitting ☐Walking ☐Other_____

• Are you pregnant? ☐ Yes ☐ No

• Do you have Allergies? Please list Ex: Peanut, Seasonal etc. _____

PLEASE, SHOW US WHERE IT HURTS ☹

Indicate your problem area(s) on the figure below: Mark the region(s) with an "X" and denote a level of pain (1-10) to *each* specific area. 1= discomfort 10=extreme pain



DESCRIBE YOUR PAIN:
- ☐Radiating
- ☐Sharp
- ☐Dull
- ☐Ache
- ☐Stabbing
- ☐Throbbing
- ☐Burning
- ☐Tingling
- ☐Intermitting

OTHER SENSATIONS:
- ☐Constant
- ☐Numbness
- ☐Fullness
- ☐Pins and Needles
- ☐Loss of Strength
- ☐Loss of Motion

Signature_____**Date**_____