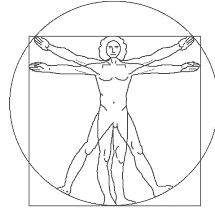
CONFIDENTIAL PATIENT CASE HISTORY



Dear Patient:

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

THANK YOU.

Name ____ Social Security # ______________

Address ____ City __________________ State ___________ Zip ______

Home Telephone ______________________ Age ______ Birthdate __/__/____ Marital Status M S W D

Work Telephone ______________________ # Chilrdren _____ Spouse's Name ________________________

Occupation ___________________ Referred by _______________________ Spouse's Office Telephone ____________

HEALTH INFORMATION:

Have you had previous chiropractic care? Y / N

What is your major complaint? ____

____

Other complaints? ____

How long have you had this condition? __________________ Have you had this or similar conditions in the past? Y / N

What activities aggravate you condition? ____

Is this condition getting progressively worse?

- ❑ Yes ❑ Constant
- ❑ No ❑ Comes and goes

Is this condition interfering with your:

- ❑ Work ❑ Sleep
- ❑ Daily routine ❑ Other ________________

How long had it been since you really felt good? ____

Other Doctors who treated this condition: ____

Have you been treated for any health conditions by a physics in he last year? Y / N

Describe____

List surgical operations and years, fractured bones? ____

____

Drugs you now take: ❑ Nerve Pills ❑ Pain Killers ❑ Muscle Relaxers " ❑ Pep" Pills ❑ Tranquilizers ❑ Insulin ❑ Birth Control Pills ❑ Others ______________________________

Age of mattress ______ years ❑ Comfortable ❑ Uncomfortable Women—Are you pregnant? ____________

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Inner Soles ❑ Arch Supports

Have you been in an auto accident? ❑ Past year ❑ Past 5 Years ❑ Over 5 years ❑ Never

Describe: ____

Have you ever had any other personal injury or accident? ❑ Past year ❑ Past 5 Years ❑ Over 5 years ❑ Never

Describe: ____

Do you suffer from:

- ❑ Alcoholism
- ❑ Allergy
- ❑ Anemia
- ❑ Arthritis
- ❑ Bed-wetting
- ❑ Bruise Easily
- ❑ Bursitus
- ❑ Cancer
- ❑ Chest pain
- ❑ Cramps
- ❑ Colds
- ❑ Colon trouble
- ❑ Deafness
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Difficulty breathing
- ❑ Difficult digestion
- ❑ Dizziness
- ❑ Ear noises
- ❑ Enlarged thyroid
- ❑ Eye pain
- ❑ Excessive menstrual flow
- ❑ Failing vision
- ❑ Fatigue
- ❑ Foot trouble
- ❑ Frequent urination
- ❑ Hay fever
- ❑ Headaches
- ❑ Hemorrhoids
- ❑ Hot flashes
- ❑ Itching
- ❑ Irregular cycle
- ❑ Kidney infection of stone
- ❑ Loss of sleep
- ❑ Lower back pain
- ❑ Low blood pressure
- ❑ Lumps in breats
- ❑ Nausea
- ❑ Neck pain or stiffness
- ❑ Nervousness/depression
- ❑ Nosebleeds
- ❑ Numbness
- ❑ Pain over heart
- ❑ Pleurisy
- ❑ Polio
- ❑ Poor circulation
- ❑ Poor posture
- ❑ Prostate trouble
- ❑ Rapid heart beat
- ❑ Sciatica
- ❑ Sinus infection
- ❑ Slow heart beat
- ❑ Spinal curvatures
- ❑ Spitting
- ❑ Stroke
- ❑ Swollen joints
- ❑ Swelling of ankles
- ❑ Tuberculosis
- ❑ Fevers
- ❑ Varicose veins
- ❑ Venereal disease
- ❑ Other (be specific)

____

____

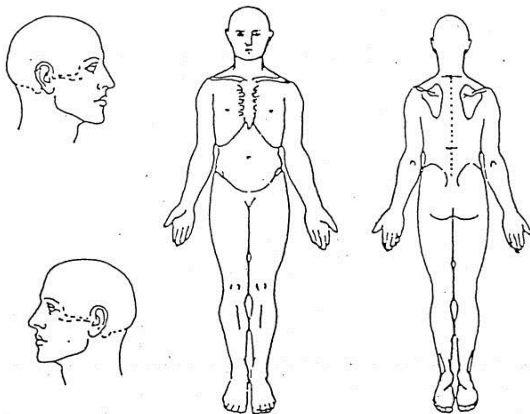
____

____

Family History

Lower Back Pain	Pain Between Shoulders	Neck Problems
____ None	____ None	____ None
____ Father	____ Father	____ Father
____ Mother	____ Mother	____ Mother
____ Sibling	____ Sibling	____ Sibling
____ Other	____ Other	____ Other
____ Unknown	____ Unknown	____ Unknown

Place X's in Areas of Pain



Habits Table

	Heavy	Moderate	None
Alcohol	❑	❑	❑
Coffee	❑	❑	❑
Tobacco	❑	❑	❑
Drugs	❑	❑	❑
Exercise	❑	❑	❑
Sleep	❑	❑	❑
Appetite	❑	❑	❑

If we participate with your insurance: deductible and copay are due at time of service.

I understand that insurance is a contract between the patient and carrier, and I am responsible for any unpaid balance for deductible, copays, and or policy limitations.

If you are a cash patient: payment is due as service is rendered.

Name: ____

Signature: ____________________________________ **Date: __/__/____**