

CONFIDENTIAL CASE HISTORY RECORD

I.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

E-mail Address _____ Cell Phone _____

Age _____ Date of Birth _____ Occupation _____ Sex (M) ___ (F) ___

Weight _____ Referred by _____

Employer _____ Address _____

Married _____ S _____ W _____ D _____ Children _____ Name of Spouse _____

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? _____ For what problem? _____

Were the results satisfactory? Yes _____ No _____ N/A _____ Major complaints and symptoms – please be as specific as you can. _____

Ask the doctor or staff for help if you need assistance in filling out this section.

How do you believe your problem (pain) began? _____

II. If you are here for an Independent Examination or Ins. second opinion, do not complete section II.

When did you first notice this problem /pain? _____

Have you lost any work? _____ Day and date you last work _____

Have you ever had this condition before or a similar condition? _____

When? _____

What positions or activities aggravate your condition? _____

What position or activities relieve your condition? _____

Have you been treated by a medical physician for this ailment? _____

Where? _____

Describe the type of treatment _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

Family physician's name _____

Please send a report to my family physician. Yes ___ No ___

Will this case be covered by any insurance company?

Medical ___ Auto ___ Blue Cross/Blue Shield ___ Workers' Compensation ___ Medicare ___

Other ___

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child?) _____

When? _____

Are you allergic to anything you are aware of? _____

Are you presently taking any medication (aspirin included)? Yes ___ No ___ If yes, name them _____

Have you ever had any broken bones? (fractures) _____ Any dislocations? _____

What operations have you had? _____ Year _____

Year _____

Year _____

Have you had any cosmetic surgery, breast implants, etc? _____ Year _____

Have you had any surgery to replace hip, knee, etc.? _____ Year _____

Have you ever had cancer? Yes ___ No ___

Does your pain ever wake you from a sound sleep? Yes ___ No ___

Are you losing weight now without trying? Yes ___ No ___

Are you coughing up blood or noticing it in your stools or urine? Yes _____ No _____

Have you had any loss of bladder or bowel control? Yes _____ No _____

Have you lost consciousness or had double vision recently? Yes _____ No _____

Are you seeing any other doctor now for **any reason**? Yes _____ No _____ Note: _____

(for women) Are you taking birth control? Yes _____ No _____ Are you pregnant? Yes _____ No _____

What was the date of onset of your last menstrual period? _____

SOCIAL HISTORY

SMOKER _____ YES or _____ NO, If Yes, How many packs _____

ALCOHOL _____ YES or _____ NO, If Yes, How much _____

III.

Did your mother or father have any of the following:

Put an **M** for mother, **F** for father, and **B** for both

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures-Convulsions |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis-Rheumatism |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Ulcer or Stomach Problems | | |

Comments: _____

Medical History

IV.

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now	Past		Now	Past
	N	P		N	P
Headaches _____ Frequency _____	_____	_____	Loss of Balance	_____	_____
Neck Pain	_____	_____	Fainting	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Sleeping Problems	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Diarrhea	_____	_____
Nervousness	_____	_____	Feet Cold	_____	_____
Tension	_____	_____	Hands Cold	_____	_____
Irritability	_____	_____	Arthritis	_____	_____
Chest Pains	_____	_____	Muscle Spasms	_____	_____
Dizziness	_____	_____	Frequent Colds	_____	_____
Shoulder/Neck/Arm Pain	_____	_____	Stomach Upset	_____	_____
Pins & Needles in Arms	_____	_____	Constipation	_____	_____
Pins & Needles in Legs	_____	_____	Cold Sweats	_____	_____
Numbness in Fingers	_____	_____	Fever	_____	_____
Numbness in Toes	_____	_____	Sinus Problems	_____	_____
High Blood Pressure	_____	_____	Diabetes	_____	_____
Difficulty Urinating	_____	_____	Hemorrhoids	_____	_____
Allergies	_____	_____	Leg Cramps	_____	_____
Weakness in Arms	_____	_____	Colitis	_____	_____
Weakness in Legs	_____	_____	Gall Bladder	_____	_____
Shortness of Breath	_____	_____	Indigestion	_____	_____
Fatigue	_____	_____	Belching	_____	_____
Depression	_____	_____	Vomiting	_____	_____

