CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you.

Name: _____Nickname:_____

Address:_____City:_____State:_____Zip:_____

Home Telephone_____ Cell Phone: _____ E-mail address: _____

BirthDate: _____ Age: _____ SS#_____

Employer, Address, Telephone:_____

Occupation and general description of physical activities involved:_____

Other activities you participate in, ie: sports, hobbies etc._____

Have you had previous chiropractic care?___yes ____no If so: Where_____When:_____

Were x-rays taken? ___yes ___no What was your problem at that time:_____

How were you referred to our office? Medical Doctor_____ Insurance Book_____Friend____ Other_____

GENERAL HEALTH INFORMATION:

Your approximate height: _____weight:_____Is your weight constant? ___yes ___no

Please check if you have ever suffered from: ___Cancer of any type ___Heart disease ___Diabetes

___Digestive disorders ___Bladder or Bowel problems ___High blood pressure, or any other vascular disease

___Stroke or TIA ___Dizziness, Blurred Vision ___Slurred speech or partial paralysis ___Allergies

Any other illness or disease_____

Family health history: Please list any major health problems your family has had, and their relationship to you:

_____

Who is your Medical Doctor:_____Date of last physical exam:_____

Any problems found:_____

Any medications you are taking: _____

Please list any surgical procedures you have had, and the year_____

Past history of any significant physical trauma, fractures, auto accidents, or other injuries: (please describe):
_____
_____

CURRENT REASON FOR CONSULTING THIS OFFICE:

What is your chief complaint: _____?

Any other complaints:_____

How long have you had this problem(s):_____

Have you seen anyone else for this condition(s), if so who, what was done, and results_____
_____

Is your condition getting progressively worse? ___yes ___no Have you had similar problems before? If so,

When, how often, etc._____

Was the onset of your current condition ___gradual or ___sudden? If sudden, what were you doing at the time

it started: _____

Was there any trauma involved with your condition, ie accident, fall etc:_____

Please describe how it feels:___sharp,___dull,___achy,___numb,___burning,___stabbing,___tingling,___stiff

Do you have any pain or numbness radiating into your arms or legs? ___yes ___no Where?_____

Is your condition constant, or does it come and go:_____

What seems to make your condition worse:_____

What seems to help:_____

On a scale of 1 to 10, with 1=no pain and 10= severe pain, what would you rate the severity of your condition?_____

Is your condition causing any interference in your activities of daily living, ie: work, sleep, lifting, bending,

driving, home care, etc. Please describe_____

Patient Signature_____ Date_____

Authorization to send narrative report to your medical doctor_____