Confidential Patient Case History Form

Part 1: General Information: (Please Print)

Name: ____________ Date: ____________ Date of birth (D/M/Y): ____________

Email Address: ____________

Address: ____________ City: ____________ Province: ____________ Postal Code: ____________

Home Phone: (____) ____________ Sex: M ☐ F ☐ M ☐ W ☐ S ☐ D ☐ (married, widowed, single, divorced) # of Children ____

Occupation or Profession: ____________ Employed by: ____________ Bus. Phone: (____) ____________

Have you been under previous chiropractic care?: Y ☐ N ☐ if yes, When?: ____________ Where: ____________

Name of person referring you: ____________ Family Physician: ____________

Do you have Chiropractic Insurance? Y ☐ N ☐

List Sports and/or Hobbies: ____________

Date of last	Less than 6 months	6-17 months	Over 18 months	Never
Spinal Exam				
Physical Exam				
Blood Test				
Urine Test				
Spinal X-Ray				
Other X-Ray				

Lifestyle habits	heavy	moderate	light	none
Alcohol				
Coffee				
Tobacco				
Prescription Drugs				
Soft Drinks				
Exercise				
Sleep				
Appetite				

Part 2: Present Health: Are you *PRESENTLY* affected by any of the following?
O – Occasionally F – Frequent C – Constant If never, leave unchecked

Muscle and Joint	O	F	C
Backache			
Neck pain			
Swollen joints			
Painful tailbone			
Foot trouble			
Shoulder pain			
Hernia			
Spinal curvature			
Faulty posture			
Arthritis			

Ears, Eyes, Nose Throat	O	F	C
Deafness			
Earache			
Ear discharge			
Sore throat			
Nosebleeds			
Hoarseness			
Hay fever			
Asthma			
Tonsillitis			
Sinus trouble			
Enlarged glands			

Stress Symptoms	O	F	C
Headache			
Dizziness			
Numbness			
Ringing in ears			
Blurred vision			
Loss of Sleep			
Concentration loss			
Nervous/Irritable			
Depression			
Decreased Energy			

Gastrointestinal	O	F	C
Difficult digestion			
Excessive hunger			
Belching or gas			
Nausea or vomiting			
Pain over stomach			
Constipation			
Colon trouble			
Liver trouble			
Gall bladder trouble			
Heartburn			
Diarrhea			
Bloody stools			

General Symptoms	O	F	C
Fever			
Chills			
Sweats			
Fainting			
Convulsions			
Allergy			
Skin Problems			
Bleeding Tendency			
Easy Bruising			
Colds			
Tremors			

Cardiovascular	O	F	C
Rapid heart beat			
Slow heart beat			
High blood pressure			
Low blood pressure			
Pain over heart			
Swelling of ankles			
Previous heart attack			
Hardening of arteries			
Poor circulation			
Previous stroke			

Respiratory	O	F	C
Chronic cough			
Spitting up phlegm			
Spitting up blood			
Chest pain			
Difficulty breathing			

Urinary	O	F	C
Painful Urination			
Getting up at night to urinate			
Blood in urine			
Increased urination			

Females Only	
Painful Menstruation	Y ☐ N ☐
Excessive flow	Y ☐ N ☐
Irregular Cycle	Y ☐ N ☐
Cramps/Backache	Y ☐ N ☐
Passed menopause	Y ☐ N ☐
Pregnant	Y ☐ N ☐
Birth Control	Y ☐ N ☐
# of Miscarriages	
Date of last menstruation period	

MOORE CHIROPRACTIC
5912 Hazeldean Road,
Stittsville, Ont. K2S 1B9
Tel 613) 831-8374 Fax (613)831-0812

Part 3: Past Health: Have you, *IN THE PAST* suffered from any of the following conditions?

Condition	Y/N	Condition	Y/N	Condition	Y/N	Condition	Y/N
Anemia	Y ☐ N ☐	Tuberculosis	Y ☐ N ☐	Emotional Problems	Y ☐ N ☐	Gout	Y ☐ N ☐
Thyroid Trouble	Y ☐ N ☐	Pneumonia	Y ☐ N ☐	Epileptic Seizures	Y ☐ N ☐	Psoriasis	Y ☐, N ☐
Diabetes	Y ☐ N ☐	Stomach Ulcers	Y ☐ N ☐	asthma	Y ☐ N ☐	Polio	Y ☐ N ☐
Rheumatic Fever	Y ☐ N ☐	Kidney Disease	Y ☐ N ☐	Allergies	Y ☐ N ☐	Cancer	Y ☐ N ☐
High Blood Pressure	Y ☐ N ☐	Back Pain	Y ☐ N ☐	HIV	Y ☐ N ☐	Venereal Disease	Y ☐ N ☐
Heart Disease	Y ☐ N ☐	Headaches	Y ☐ N ☐	Arthritis	Y ☐ N ☐	Alcoholism	Y ☐ N ☐
Other							

Please list any significant illnesses, operations, accidents, or falls:

Date	Illness/Operation/Accident/Fall/Other

Part 4: Family Health: Has any blood relation had any of the following?

Condition	Y/N	Condition	Y/N	Condition	Y/N	Condition	Y/N
Tuberculosis	Y ☐ N ☐	Kidney Disease	Y ☐ N ☐	Epilepsy	Y ☐ N ☐	Arthritis	Y ☐ N ☐
Heart Disease	Y ☐ N ☐	Diabetes	Y ☐ N ☐	Mental Illness	Y ☐ N ☐	Cancer	Y ☐ N ☐
High Blood Pressure	Y ☐ N ☐	Low Blood Pressure	Y ☐ N ☐	Strokes	Y ☐ N ☐	Allergies	Y ☐ N ☐
Migraine Headaches	Y ☐ N ☐	Other					

Part 5: Are you:

Presently wearing custom made foot orthotics? Yes ☐ No ☐

Interested in being fitted for custom made orthotics? Yes ☐ No ☐

Part 6: Do you:

Now take vitamins or minerals? Yes ☐ No ☐

Think you may need vitamins or minerals? Yes ☐ No ☐

Feel you have proper nutritional habits? Yes ☐ No ☐

Part 7: Present reason for consulting our office (Please check only one)

I have a disease/symptom and I am ONLY interested in help with this specific problem------------------------- ☐

I have a disease/symptom and I am interested in help with this problem, and in learning how to prevent it in the future---------------------------- ☐

I have a disease/symptom and I am interested in help with this problem, in addition I am interested in learning about my Heath Potential and the role of chiropractic in improving my family's heath------------------------------ ☐

I have no special problem; I understand or am interested in the role of chiropractic in my general heath care------------------------------ ☐

Part 8: Please list any major symptoms:

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Part 9: How long have you had these symptoms?:

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