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Chiropractic Physician

CONFIDENTIAL CASE HISTORY

Patient Name: _____ Date: _____

Sex: M F Age: _____ Birthday: _____ Marital Status: _____ Ages of Children: _____

Spouse or Parent Name: _____ Right or Left handed (circle): Referred By: _____

Occupation & Employer _____

Previous D.C. (Doctor of Chiropractic) & address: _____

Date of last D.C. visit: _____ Reason: _____

Present Family Doctor or other M.D./D.O. & address: _____

Date of last M.D./D.O. visit: _____ Reason: _____

Please describe the health complaint(s) that caused you to seek our care today: _____

Do you now have, or have you ever had, any symptoms or conditions in any of the following areas? If yes, please list below.
(Circle "Y" for yes and "N" for no.)

Y N CARDIOVASCULAR SYSTEM (Heart & Blood Vessels): _____

Y N PULMONARY SYSTEM (Breathing & Lungs): _____

Y N GASTROINTESTINAL SYSTEM (Stomach, Intestines, & Digestion): _____

Y N URINARY SYSTEM (Kidneys, Prostate, Bladder, & Urination): _____

Y N EARS, EYES, NOSE & THROAT: _____

Y N NEUROLOGICAL SYSTEM (Brain, Spinal Cord, & Nerves): _____

Y N Stroke or TIA Y N Dizziness Y N Arm Pain or Numbness Y N Leg Pain or Numbness

Y N MUSCULOSKELETAL SYSTEM (Muscles, Tendons, Ligaments, Joints, & Bones): _____

Y N Low Back Pain Y N Neck Pain Y N Mid Back Pain Y N TMJ (jaw) Problems Y N Headaches

Y N REPRODUCTIVE SYSTEM: _____

Y N Are you presently pregnant or attempting to become pregnant? Y N Have you had a hysterectomy?

Patient Name: _____ Date: _____

Do you now have, or have you ever had, any of the following symptoms or conditions?

- | | | |
|----------------|------------------------------------|-------------------------------------|
| Y N Diabetes | Y N Thyroid disease | Y N A.I.D.S. |
| Y N Cancer | Y N Insomnia (difficulty sleeping) | Y N Unexplained weight loss or gain |
| Y N Depression | Y N Psychological problems | Y N Do you presently have a fever? |
- Y N Do you presently smoke cigarettes? How many per day? _____ For how many years? _____
- Y N Have you ever smoked? When did you stop? _____ How many years did you smoke? _____
- Y N Do you presently drink alcohol? Type & Amount each month: _____
- Y N Do you take vitamins or nutritional supplements? _____
- Y N Have you ever been given an impairment rating or been declared disabled?

Please list any work related injuries, auto accidents, or serious falls or injuries (include sports injuries) in your past: _____

Please list any OTHER CONDITIONS you have experienced, not already covered in this case history: _____

Please list past HOSPITALIZATIONS and SURGERIES, not already covered: _____

Please list all MEDICATIONS (include over-the-counter) you are presently taking and for what conditions: _____

Please list your PHYSICAL ACTIVITIES (include sports, exercise, and active entertainment): _____

FAMILY HISTORY

Have any of your blood relatives experienced the following conditions?

- | | | |
|---------------|-------------------|-----------------------------------|
| Y N Headaches | Y N Arthritis | Y N Epilepsy or other seizures |
| Y N Stroke | Y N Cancer | Y N Back or neck problems |
| Y N Diabetes | Y N Heart disease | Other significant problems: _____ |

To the best of my knowledge, the above statements are correct and complete.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____