CONFIDENTIAL PATIENT CASE HISTORY

Date: ____________________

Patient Name:	____________________	DOB:	____________	Age:	______
Address:	____________________	SSN:	____________		
City / St/ Zip:	____________________	Spouse:	____________	Age:	______
Phone:	____________________	Referred by:	____________		
Cell:	____________________	# of children:	____________		
Other:	____________________	Child 1 Name:	____________	Age:	______
Email:	____________________	Child 2 Name:	____________	Age:	______
Employer:	____________________	Child 3 Name:	____________	Age:	______
Occupation:	____________________	Child 4 Name:	____________	Age:	______

Who is financially responsible for your services?: ____________________

Insurance that may pay for your care: ____________________

CURRENT CONDITION

Did an auto accident or work injury prompt this visit? Yes / No How long have you had this problem? ______

Have you had similar or same condition before? Yes / No When: ______

What is the primary reason for today's visit? ____________________

When it's at its worst, what does it feel like? ____________________

Was onset gradual or sudden? ____________________

With what activities does it interfere the most? (Sleep, work, etc…) ____________________

What other doctors have you seen for this condition? ____________________

Has anyone recommended drugs or surgery for this condition? ____________________

Many (perhaps even most) problems in our bodies start out as short-circuits in our nervous systems. Since almost all of these points of nerve distress our foundation in the spine, it is very important to know what jolts and accidents may have tilted or twisted your vertebrae from their normal positions.
Think hard!

PLEASE DESCRIBE WHAT HAPPENED AND IN WHAT YEAR (APPROXIMATELY) IT TOOK PLACE:

Scale of 1 - 10
(1 = not much / 10 = very bad)

Auto Accidents:	____________________	Year: ________	How severe? ______
Auto Accidents:	____________________	Year: ________	How severe? ______
Low back injury:	____________________	Year: ________	How severe? ______
Fell or slipped:	____________________	Year: ________	How severe? ______
Motorcycle accident:	____________________	Year: ________	How severe? ______
Hit your head:	____________________	Year: ________	How severe? ______
Neck injury / stiffness:	____________________	Year: ________	How severe? ______
Sport injuries:	____________________	Year: ________	How severe? ______
Sport injuries:	____________________	Year: ________	How severe? ______
Wrist / Neck injury:	____________________ (ie… Computer work, holding phone with shoulder, etc)	Year: ________	How severe? ______
Other:	____________________	Year: ________	How severe? ______
	____________________	Year: ________	How severe? ______
	____________________	Year: ________	How severe? ______

Have you ever been put 'under' with general anesthetic?: Yes / No If YES, how many times: ______

THE RESULTS YOU HOPE TO ACHIEVE THROUGH COMING TO THIS OFFICE

Relieve the immediate pain and discomfort: Yes / No

Spine improved enough that it will 'hold together' for a few months: Yes / No

Spine and nerve system improved as much as possible and maintained in top condition: Yes / No

SURGERIES

Tonsils	Yes / No	Prostate	Yes / No
Tubes in Ears	Yes / No	Hernia	Yes / No
Thyroid	Yes / No	Hysterectomy	Partial _____ Complete _____

DRUGS TAKEN OR HAVE TAKEN IN THE LAST 10 YEARS

Drug	Yes / No	If yes, how long?
Thyroid Medication	Yes / No	If yes, how long? ______
Birth Control Pills	Yes / No	If yes, how long? ______
High Blood Pressure Drugs	Yes / No	If yes, how long? ______
Corticosteroids	Yes / No	If yes, how long? ______
Tranquilizers	Yes / No	If yes, how long? ______
Diuretics	Yes / No	If yes, how long? ______
Sleeping Pills	Yes / No	If yes, how long? ______
Hormones	Yes / No	If yes, how long? ______
Pain Killers (Advil, Tylenol, Aspirin, etc.)	Yes / No	If yes, how long? ______

PLEASE MARK THE SYMPTOMS YOU NOW HAVE OR HAVE RECENTLY HAD

Symptom	Occasionally	Frequently	Constantly
Headaches	☐	☐	☐
Dizziness	☐	☐	☐
Nervousness	☐	☐	☐
Insomnia	☐	☐	☐
Hyperactivity	☐	☐	☐
Ringing in Ears	☐	☐	☐
Swollen Throat Glands	☐	☐	☐
Tonsillitis	☐	☐	☐
Laryngitis	☐	☐	☐
Shakiness in Hands	☐	☐	☐
Trouble Staying Warm	☐	☐	☐
Arms Feel Heavy	☐	☐	☐
Chest Pains or Tightness	☐	☐	☐
Out of Breath Easily	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Pneumonia	☐	☐	☐
Cold Sores	☐	☐	☐
Sick After Eating Fats	☐	☐	☐
Heartburn	☐	☐	☐
Gas	☐	☐	☐
Groggy after Meals	☐	☐	☐
Allergic to some foods	☐	☐	☐
Indigestion	☐	☐	☐
Cravings for Sweets	☐	☐	☐
Poor Energy	☐	☐	☐
Allergies	☐	☐	☐
High Blood Pressure	☐	☐	☐
Complexion Problems	☐	☐	☐
Depression	☐	☐	☐
Headaches with Nausea and Blurry Vision	☐	☐	☐
Stiffness in Joints	☐	☐	☐
Swollen Ankles	☐	☐	☐
Cramps in Legs	☐	☐	☐
Pain or Numbness in LEGS	☐	☐	☐
Pain in Hips	☐	☐	☐
Pain or Numbness in THUMB or INDEX FINGER	☐	☐	☐
Pain or Numbness in the FACE	☐	☐	☐
Pain or Numbness in HANDS or ARMS	☐	☐	☐
Pain Between Ribs	☐	☐	☐
Poor Concentration or Memory	☐	☐	☐

Symptom	Occasionally	Frequently	Constantly
Frequent Urination	☐	☐	☐
Bladder Infection	☐	☐	☐
Painful Urination	☐	☐	☐
Bed Wetting	☐	☐	☐
Constipation	☐	☐	☐
Distended Abdomen	☐	☐	☐
Diarrhea	☐	☐	☐
Hemorrhoids	☐	☐	☐
Upper Neck Pain	☐	☐	☐
Lower Neck Pain	☐	☐	☐
Upper Back Pain	☐	☐	☐
Low Back Pain	☐	☐	☐

WOMEN ONLY

Symptom	Occasionally	Frequently	Constantly
Irregular Heavy Period	☐	☐	☐
Bladder Leakage	☐	☐	☐
Cramps	☐	☐	☐
PMS	☐	☐	☐
Breast Tenderness	☐	☐	☐
Hot Flashes	☐	☐	☐
Miscarriage	☐	☐	☐
Can't Get Pregnant	☐	☐	☐

HAVE YOU HAD?

Condition	Yes / No
Cancer	Yes / No
Heart Disease	Yes / No
Rheumatoid Arthritis	Yes / No
STD	Yes / No
AIDS	Yes / No
Migraine Headaches	Yes / No
Carpal Tunnel Syndrome	Yes / No
Thyroid Trouble	Yes / No
Hiatal Hernia	Yes / No
Colitis	Yes / No
Osteoporosis	Yes / No
Gall Bladder Trouble	Yes / No
Alcoholism	Yes / No
Diabetes	Yes / No
Epilepsy	Yes / No

I understand and agree that health and accident insurance policies are arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor's Office for X-rays is for examination only and X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions for any medical diagnosis. Patient affirms that all information given is true and accurate to the best of his/her knowledge.

____

Patient's / Guardian's Signature　　　　　　　　　　Date