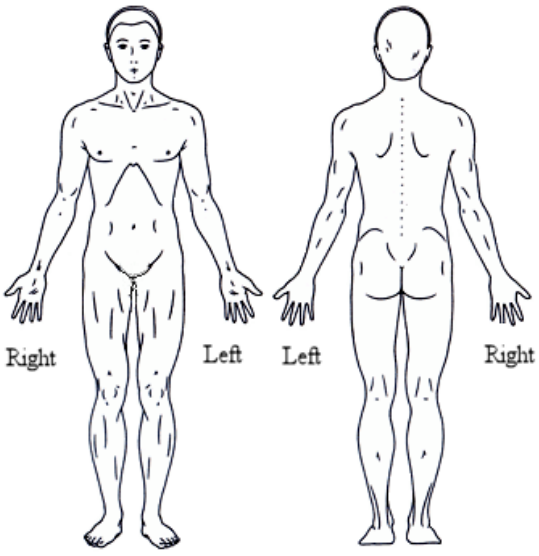
# CONFIDENTIAL CASE HISTORY

Name _____Date of Birth _____Age _____Date _____
Address _____ City _____ State_____ Zip_____
Phone (Home) _____ Phone (Cell) _____ Email _____
Sex: M/F Marital Status: S/M/D/W Ages of Children _____ Social Security # _____
Occupation & Employer _____ Phone (Work)_____
Spouse's Name _____Spouse's Occupation _____
Spouse's Employer _____Spouse's Phone (Work)_____
Emergency Contact: Name_____ Phone _____
How were you referred to our office?_____

**HEALTH REPORT:**

Primary reason for seeking care: _____
Secondary reason for seeking care: _____
List other doctors/practitioners seen for this: _____
List diagnosis and type of treatment: _____
Other things you have tried: _____
Is present condition due to an injury? Yes/No: On the Job __ Auto Accident __ Other _____
Has the accident been reported? Yes/No: To Employer __ Auto Carrier __ Other _____
Have you had similar accidents or injuries before? Yes/No If yes, explain: _____
List the names of any relatives that have or have had a similar problem: _____
Have you received chiropractic treatment previously? Where/When: _____
Have you been treated for any other health condition in the last year? Yes/No If yes, explain: _____
_____
Medication _____Dosage _____Frequency _____Condition_____
Medication _____Dosage _____Frequency _____Condition_____
Medication _____Dosage _____Frequency _____Condition_____
Have you taken other medications in the past? If yes, list medications _____
Surgery_____Date_____Condition_____
Surgery_____Date_____Condition_____
Vitamins/Supplements: _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____




Please circle the **LEAST** to **MOST** levels of your usual daily experience of pain or discomfort below:
(None) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)
Using the symbols below, mark on the pictures where you feel pain or discomfort:

| | |
|---|---|
| Numbness | = = = |
| Dull Ache | OOO |
| Burning | XXX |
| Sharp/Stabbing | / / / |
| Pins, Needles | + + + |
| Other _____ | ^ ^ ^ |

What aggravates your condition/pain?_____
What lessens your condition/pain?_____
Is this condition worse certain times of the day? Y/N:_____
Is this condition interfering with Home?_____ Work?_____
Sleep?_____ Recreation?_____ Other?_____
Is this condition progressively getting worse? _____

**FAMILY HISTORY**: Health conditions, cause and age at death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____

**PERSONAL HABITS:**

Do you smoke Y/N: #/day__ Alcohol Y/N: Daily __Weekly __Social Occasions__ Caffeinated drinks/day___
Hours of sleep per night: _____ Sleep Quality Scale: (None/Poor Sleep) 0 1 2 3 4 5 6 7 8 9 10 (Rested)
Hours of the day you spend: Sitting_____ Standing_____ Light Labor_____ Heavy Labor_____
Days a week you exercise 30 minutes or more:___ Exercise Intensity: (Low) 0 1 2 3 4 5 6 7 8 9 10 (High)
Types of exercise: _____
Physical stress level: 0 1 2 3 4 5 6 7 8 9 10 (High). Emotional stress level: 0 1 2 3 4 5 6 7 8 9 10 (High)
List your major stressors: _____
What are you health goals? _____

**Please mark each item below for each condition you have NOW (N) or had PREVIOUSLY (P):**

**GENERAL SYMPTOMS**
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

**MUSCLES & JOINTS**
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems R/L
__ Leg Problems R/L
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones_____

**CARDIO-VASCULAR**
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

**EAR/NOSE/THROAT**
__ Earache
__ Ear Noises (tinnitus)
__ Hypo/Hyper Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

**GASTRO-INTESTINAL**
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Pain/Stones
__ Hemorrhoids
__ Liver problems
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

**RESPIRATORY**
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

**GENITO-URINARY**
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection/Stones
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

**SKIN OR ALLERGIES**
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

**FOR WOMEN ONLY**
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
__ Pre/Post menopausal
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature_____ Date_____
Representative Signature (if minor) _____ Date_____