Confidential Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU!

Name _____ Date of Birth _____ Sex □M □F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____

Social Security Number _____ Occupation _____

Marital Status □ M □ S □ D □ W Spouse's Name _____

Children's Names & Ages _____

Who referred you to us? _____ _____

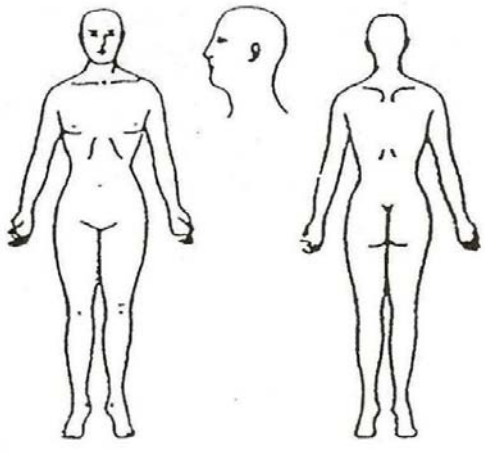
How else did you hear about us? _____

Health History Questionnaire

1. What brings you into this office (e.g. want to be healthier, backache, heartburn, etc.)?
   _____
2. If you are experiencing a symptom:
   a. When did it begin? _____
   b. How did it happen? _____
   c. How often does it affect you? □constant □intermittent
   d. Symptom severity is currently: □mild □moderate □severe
   e. Symptom is currently: □increasing □decreasing □not changing
   f. Symptom is worse in the: □morning □afternoon □night □same all day
   g. If there is pain, is it: □sharp □dull □ache □shooting □tingling □radiating □stabbing □other_____
   h. What makes the symptom better? □nothing □sitting □lying down □walking □moving □bending/twisting □other_____
   i. What makes the symptom worse? □nothing □sitting □lying down □walking □moving □bending/twisting □other_____
   j. How have you treated the symptom? □ice □heat □medication □other_____
   k. Have you seen another provider for this complaint? □yes □no
      If so, who: □Chiropractor □MD □Osteopath □Specialist □other_____
      When and what was their treatment_____
   l. Has this condition affected your: □sleep □work □chores □family/social life □leisure □other_____
   m. Have you had this or similar conditions in the past? _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles ···· Stabbing ////



3. What do you hope to gain from this office?

   □improved general health □symptom relief □increased productivity □positively change my life □other_____

4. Have you suffered injuries in the past? □yes □no

   □car accident date_____ □falls date_____ □hospitalization date_____

   □fracture date_____ □sprain/strain date_____ □other_____

5. Do you have a family history of:

   □heart disease □cancer □arthritis □diabetes □lung conditions □high blood pressure

   □stroke/vascular problems □kidney or liver conditions □other_____

6. Do you have a family physician? Name: _____

7. Please list any disease or condition with which you have been diagnosed _____

   _____

8. Please list any medications or supplements that you are currently taking _____

   _____

9. Please list any surgical operations and dates _____

   _____

Review of Systems

Past	Present		Past	Present	
□	□	Neck or back pain	□	□	Visual disturbances
□	□	Headaches	□	□	Dizziness
□	□	Jaw pain	□	□	Ear noises or ringing
□	□	Arm, shoulder, elbow, wrist or hand pain	□	□	Hard of Hearing
□	□	Leg, hip, knee, ankle or foot pain	□	□	Earache
□	□	Swelling or stiffness of joints	□	□	Ear Fluid
□	□	Numbness, loss of sensation, or tingling	□	□	Shortness of breath or wheezing
□	□	General fatigue	□	□	Chronic cough or chronic sinusitis
□	□	Depression	□	□	Runny nose or post nasal drip
□	□	Troubled sleep	□	□	Throat soreness or hoarseness
□	□	Loss of memory	□	□	Chronic ear or throat infections
□	□	Fainting	□	□	Loss of taste or appetite
□	□	Seizures	□	□	Abnormal weight gain or loss

☐ ☐ Excessive thirst
☐ ☐ Heat or cold intolerance
☐ ☐ Loss of bladder control
☐ ☐ Painful or frequent urination
☐ ☐ Bladder infection
☐ ☐ Kidney disorder or stones
☐ ☐ Abdominal pain
☐ ☐ Constipation/irregular bowel habits
☐ ☐ Liver or gallbladder problems
☐ ☐ Hernia
☐ ☐ Irritable bowel or colitis
☐ ☐ Nausea
☐ ☐ Bloating or gas
☐ ☐ Diarrhea
☐ ☐ Hemorrhoids
☐ ☐ Difficulty swallowing
☐ ☐ Heartburn or indigestion
☐ ☐ Ulcer
☐ ☐ Aortic aneurysm
☐ ☐ High blood pressure
☐ ☐ Heart murmur
☐ ☐ Heart palpitations
☐ ☐ Chest pains or angina
☐ ☐ Heart attack
☐ ☐ Stroke
☐ ☐ Asthma or Allergies
☐ ☐ Skin rashes
☐ ☐ Cancer or non-cancerous tumor
☐ ☐ Blood disorder
☐ ☐ Emphysema
☐ ☐ Arthritis (or Rheumatoid arthritis)
☐ ☐ Diabetes
☐ ☐ Hepatitis
☐ ☐ Epilepsy
☐ ☐ Lupus
☐ ☐ HIV/AIDS
☐ ☐ Other_____

Current Weight _____

Women Only

☐ ☐ Irregular menstrual flow
☐ ☐ Breast soreness or lumps
☐ ☐ Menstrual cramping
☐ ☐ PMS
☐ ☐ Endometriosis
☐ ☐ Recurrent yeast or fungal infection
☐ ☐ Hot flashes

Duration of cycle _____ Duration of flow _____
Menstrual flow: ☐ Heavy ☐ Moderate ☐ Light
Last period _____
No. Pregnancies _____ No. Births _____
Contraception Type _____

Men Only

☐ ☐ Prostate problems
☐ ☐ Erectile dysfunction
☐ ☐ Testicular pain

Please list any other health concerns you have that you would like the doctor to be aware of _____
_____

Patient Signature: _____ **Date:** _____

Parent/ Guardian signature: _____