

PATIENT CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Social Security No. _____ Driver's License No. _____
Age _____ Birthdate _____ Sex _____ Marriage Status: M S W D No. Children _____
Occupation _____ Employer _____
Employer's Address _____ Work Phone _____
Spouse's Name _____ Occupation _____ Employer _____
Height _____ Weight _____ Referred by _____

Present Complaint or Illness _____

Duration _____
Events Preceding Onset _____

How Long Since You've Been Well _____

Personal Health Goals _____

Have you had any of the following? If yes, briefly describe:

Accidents: _____

Surgery: _____

Vaccinations: _____

Women Only:
Onset Menstruation _____
No. of Children _____ Complications _____
No. of Miscarriages _____ C-Sections _____
Menopause _____
_____ Menstrual pain _____ Cramping _____ Irregularity _____
Date of last period _____
Are you now pregnant? _____ yes _____ no How long? _____

If you have had any x-rays in last 2 years, please list by whom, when, and what part of the body: _____

List types of exercise you normally do: _____

Hours of sleep you usually have _____ Are they interrupted? _____
What position is your body in during sleep? _____

Have you seen a Doctor of Chiropractic before? _____ Who? _____
Are you skeptical of seeing a Chiropractor? _____

Amount of alcohol you consume per day _____ per week _____ per month _____
Number of cigarettes you smoke per day or week _____ Glasses of water you consume per day _____

Cups of coffee per day _____ Number of bowel movements per day _____
Do you use white sugar? _____

Are you encountering outside stresses from family, work, etc. which may be adversely affecting you? _____

List any health problems or abnormalities you may have that are associated with being in foreign countries: _____

Have you seen anyone else regarding this situation? If so, who, when, what was the diagnosis, treatment and results: _____

List all Prescription, over-the-counter or recreational drugs that you are currently using: _____

List medications or drugs which you have taken in the past: _____

Have you ever been under the care of a psychiatrist or psychologist? _____

Medical History: Check any diseases which you or your relatives have had.

Relatives	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Gout	Heart Disease/Stroke	High Blood Pressure	Hypothyroidism	Kidney Disease	Neurological Disease	Stomach Ulcer	Periodontal Disease	Tuberculosis	Atherosclerosis	Obesity	Senility
You																		
Father																		
Mother																		
Brothers																		
Sisters																		
Spouse																		
Children																		
Grandparents																		

Check any other illnesses which you now have or have had.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hives | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Attempted Suicide | <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting or dizzy | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sialica |
| <input type="checkbox"/> Benign Breast Tumor | <input type="checkbox"/> Spells | <input type="checkbox"/> Major Surgery | <input type="checkbox"/> Skin Ulcers |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Malaria | <input type="checkbox"/> Skipped Heart Beats |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Candida Albicans | <input type="checkbox"/> Gingivitis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Myopia | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Nervous Breakdown | Other _____ |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Nervousness | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neuralgia | _____ |
| | <input type="checkbox"/> Hernia | <input type="checkbox"/> Night Blindness | _____ |

Will you be paying for the visits yourself, or would you like this billed through your Health Insurance? _____

Insurance company name _____

Address _____

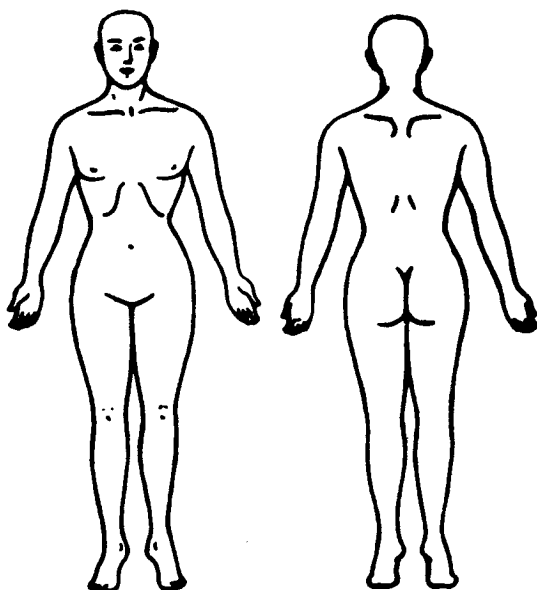
Certificate Number _____ Group Number _____

Is this an injury due to Automobile Accident or a work related accident? _____

Do you have a lawyer regarding your accident? Name _____

Address _____ Phone # _____

Please **mark** areas of pain or injury on the illustrations below and give a word description of the symptoms you are experiencing in those areas:



Signature _____

Date _____