PATIENT CASE HISTORY

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Social Security No. _____ Driver's License No. _____

Age _____ Birthdate _____ Sex _____ Marriage Status: ☐ ☐ ☐ ☐ 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.

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

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

Insurance company name _____

Address _____

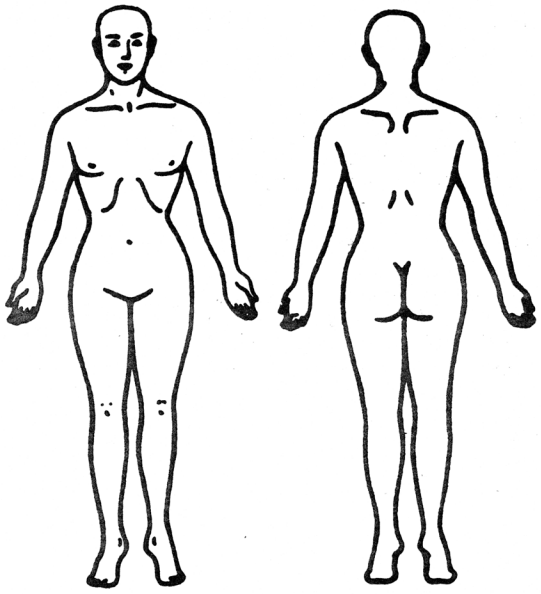
Certificate Number _____ Group Number _____

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:



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Signature

Date