

# CONFIDENTIAL PATIENT CASE HISTORY

## HEALTH INFORMATION



Name: \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

How did this problem begin (eg. fall, lifting, etc.)? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

What relieves your condition? \_\_\_\_\_

Other doctors who treated this condition: \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Other complaints: \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Drugs you now take:  Nerve pills  Muscle relaxers  Pain Killers  "Pep" pills  Insulin  
 Tranquilizers  Birth control pills  Others: \_\_\_\_\_

Vitamins/Supplements you now take: \_\_\_\_\_

Sleeping position:  back  side  stomach Do you wear:  Heel lifts  Arch supports

Have you ever been in a motor vehicle accident?  No  Yes When? \_\_\_\_\_

Were you injured?  No  Yes (describe): \_\_\_\_\_

Have you had any other personal injury or accident?  No  Yes (when?): \_\_\_\_\_

Describe: \_\_\_\_\_

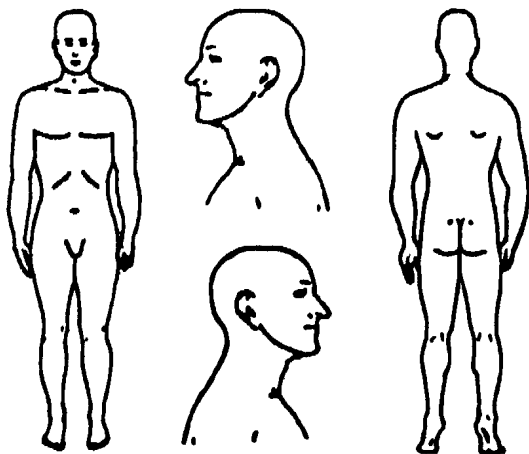
Is there a family history of:  Heart Disease  Cancer  Stroke Describe: \_\_\_\_\_

Do you have any children?  No  Yes (ages): \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Do you exercise?  No  Yes (what forms and how often): \_\_\_\_\_

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



Have you in the past or do you presently suffer from Any of the following?

<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	1. Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	2. Backaches
<input type="checkbox"/>	<input type="checkbox"/>	3. Heart Trouble
<input type="checkbox"/>	<input type="checkbox"/>	4. Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	5. Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	6. Headaches
<input type="checkbox"/>	<input type="checkbox"/>	7. Asthma
<input type="checkbox"/>	<input type="checkbox"/>	8. Neuritis
<input type="checkbox"/>	<input type="checkbox"/>	9. Digestive Disorders
<input type="checkbox"/>	<input type="checkbox"/>	10. Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	11. Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	12. Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	13. High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	14. Painful menstrual cycle
<input type="checkbox"/>	<input type="checkbox"/>	15. Cancer

Have you ever had chiropractic care?  No  yes  
When? \_\_\_\_\_ Why? \_\_\_\_\_  
Where? \_\_\_\_\_  
Were X-rays taken?  No  Yes  
When was your last adjustment? \_\_\_\_\_

Present reason for consulting the office:  
 Improving self and/or family health  
 Maximizing personal health potentials  
 Preventing disease and/or symptoms  
 Disease and/or symptoms