CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:
Please complete this questionnaire. Your answers will help us to determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **THANK YOU.**

Name _____Social Security #_____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birth Date _____ Marital Status: M S W D

Work Telephone _____ # Children _____ Spouse's Name _____

Cell Number _____ Email Address: _____

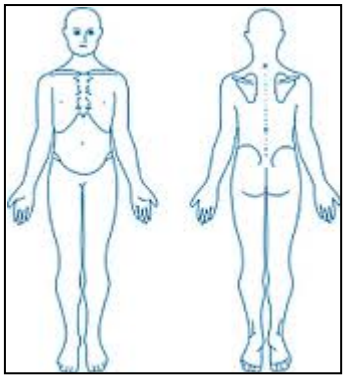
Occupation _____ Referred By _____ Sex: ☐ Male ☐ Female

HEALTH INFORMATION: Have you had previous chiropractic care? _____ If yes, when?_____

1. What is your major complaint? _____

Other Complaints: _____

2. Where is the symptom? _____



3. When did the ***symptom first*** start? _____
Have you had this or similar conditions in the past? _____

4. How would you describe your pain? (Check more than one if necessary to describe your problem)
☐ Stiffness ☐ Weakness ☐ Sharp ☐ Dull ☐ Burning ☐ Numbness & Tingling
☐ Pressure ☐ Throbbing ☐ Tearing ☐ Achy ☐ Soreness ☐ Travels ☐ Constant
☐ Comes & Goes ☐ Making a Grinding Noise ☐ Knot

5. When at it's worst rate the severity of your problem: Best 1 2 3 4 5 6 7 8 9 10 Worst

6. What activities aggravate your condition? (Check more than one if necessary to describe your problem)
☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Bending ☐ Coughing ☐ Lying down ☐ Trying to Sleep
☐ Walking ☐ Chores ☐ Stress ☐ Movement ☐ Standing after Sitting ☐ Sitting down after Standing
☐ Flexion ☐ Extension ☐ Turning Left ☐ Turning Right ☐ Bending Left ☐ Bending Right
☐ Running ☐ Sex ☐ Driving ☐ Exercising ☐ Walking up/down stairs

Please outline on the diagram the area of your discomfort.

7. It interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

8. What alleviates your condition? (Check more than one if necessary to describe your problem)
☐ Resting ☐ Sitting ☐ Standing ☐ Using Ice ☐ Using Heat ☐ Stretching ☐ Moving Around ☐ Adjustments ☐ OTC Medication
☐ Laying down ☐ Massage ☐ Prescription Medication ☐ Taking Time off Work ☐ Sleeping ☐ Exercising

9. How long has it been since you really felt good?_____

10. Other doctors who treated this condition _____

11. List surgical operations and years: _____

12. Age of Mattress: ____ ☐ Comfortable ☐ Uncomfortable **12.** Date of last physical exam: _____

Drugs you now take:
☐ Pain Killers ☐ Nerve Pills ☐ Muscle Relaxers ☐ Insulin ☐ Hormones ☐ Tranquilizer ☐ Birth Control
☐ Mood Related Drugs ☐ Blood Pressure Medication Other _____

At our office we are not only interested in your well being, but also the health and well being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:
Children _____
Spouse _____
Mother/ father _____
Siblings _____

FEMALE ONLY: Is there any chance that you may be pregnant? ☐Yes ☐ No

Have you been in an auto accident? _____ Past Year _____ Past 5 years _____ Over 5 years _____ Never
Describe: _____

Have you had any personal injury or accident? ____ Past Year ____ Past 5 years _____ Over 5 years _____ None
Describe: _____

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood Years	Yes	No	Unsure
Did you have any childhood illness?	☐	☐	☐
Was there a prolonged use of medicine?	☐	☐	☐
Did you have any falls from height Over 3 feet (i.e. crib, bunks)	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/ use any drugs?	☐	☐	☐

Adult Years (18-present)	Yes	No	Comments
Do/Did you smoke?	☐	☐	_____
Do/ Did you drink alcohol?	☐	☐	_____
Have you been in any accidents?	☐	☐	_____
Do/Did you play adult/extreme sports?	☐	☐	_____

Have you suffered from?

☐ Arthritis	☐ Numbness in fingers/hands	☐ Low Back Pain	☐ Pins & Needles
☐ Fatigue	☐ Headaches	☐ Mid Back Pain	☐ Cold Feet /Cold Hands
☐ Asthma	☐ Neck Pain	☐ Backaches	☐ Dizziness
☐ Sinus Trouble	☐ Pain between shoulders	☐ Hip Pain / Thigh Pain	☐ Loss of Balance
☐ Sleep Disorders	☐ Shoulder pain	☐ Knee Pain	☐ Ringing/Buzzing ears
☐ Digestive Disorders	☐ Arm Pain	☐ Pain Down Back or Leg	☐ Mood Swings /Depression
☐ Allergies	☐ Elbow Pain	☐ Numbness in toes/feet	☐ Tension
☐ Heart Trouble	☐ Hand/finger/wrist pain	☐ Concentration Problems	☐ Nervousness
☐ Diabetes	☐ Carpal Tunnel	☐ Menstrual pain/irregular	☐ Other _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No
If yes, Name of Company_____ Policy # _____

Are you covered by Medicare? ☐ No ☐ Yes If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic office will be credited my account or receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

CCWC USE ONLY:
Reviewed: _____ Date: _____ROF Date:_____