

**CONFIDENTIAL PATIENT CASE HISTORY**

**Patient Information:**

Name \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ email \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ Check One:  Married  Single  Widowed  Divorced  Separated No. Of Children \_\_\_\_\_  
Business/Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Spouse Information:**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

**Emergency Contact Information:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Policyholder - Insurance Information:**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
SS# \_\_\_\_\_ Insurance ID # \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Type of Insurance:  Worker's Comp  Auto  Medicare  Medicaid

**CURRENT HEALTH CONDITION**

Purpose of Appointment \_\_\_\_\_  
When did this condition begin? \_\_\_\_\_ How long have you had this condition? \_\_\_\_\_ Has it occurred before? \_\_\_\_\_  
How many times? \_\_\_\_\_ What makes condition worse? \_\_\_\_\_ Other Doctors Seen for this condition \_\_\_\_\_  
Treatments Received \_\_\_\_\_ Results \_\_\_\_\_  
Drugs you now take \_\_\_\_\_

**PAST HEALTH HISTORY**

Please check and describe any Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  
 Back Surgery  Broken Bones  Other \_\_\_\_\_  
Major Accidents or Falls \_\_\_\_\_  
Other Hospitalizations \_\_\_\_\_  
Previous Chiropractic Care  None  Doctor's Name and Date of last Visit \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:**

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        | <b><u>INTAKE</u></b>                 |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Coffee      |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Tea         |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Alcohol     |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental disorders | <input type="checkbox"/> Cigarettes  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Addictions       | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           |                                      |

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL**

- Low Back Pain
- Pain Between Shoulder
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness

**NEUROLOGICAL SYSTEM**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**GENERAL**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

**FEMALES ONLY**

- Last Period Date \_\_\_\_\_
- Are you pregnant?
- Yes  No  Not Sure

**GENITO-URINARY**

- Bladder Trouble
- Painful Urination
- Excessive Urination
- Discolored Urine

**CARDIO-VASCULAR**

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems
- Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**EENT**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

**FEMALE/MALE**

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain
- Vaginal Infection
- Breast Pain/Lumps
- Prostate Problems
- Sexual Dysfunction

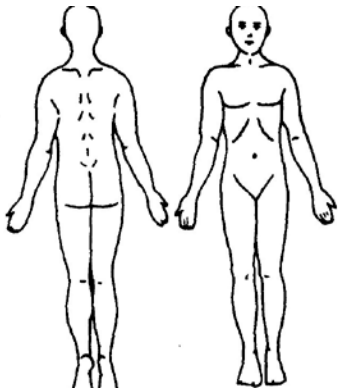
**FAMILY HISTORY MEMBER**

- High Blood Pressure \_\_\_\_\_
- Thyroid Problems \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Stroke \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Cancer \_\_\_\_\_
- Tumors \_\_\_\_\_
- Other Illness \_\_\_\_\_

**GASTRO-INTESTINAL SYSTEM**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Heartburn Gas/Bloating after Meals
- Black/Bloody Stool
- Colitis

**DOCTOR'S NOTES:**



**OUTLINE YOUR AREA OF PAIN**