

# Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us 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 \_\_\_\_\_ Date \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**O – Occasional**  
**F – Frequent**  
**C – Constant**

- |                          |                          |                          |                        |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>General</b>         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergy                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chills                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of sleep          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of weight         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness/depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuralgia              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sweats                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tremors                |

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|--------------------------|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Muscle &amp; Joint</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bursitis                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foot trouble              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hernia                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low back pain             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumbago                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck pain or stiffness    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain between shoulders    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain or numbness in:      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shoulders                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arms                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Elbows                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hands                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hips                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Legs                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Knees                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feet                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful tail bone         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor posture              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sciatica                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spinal Curvature          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints            |

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|--------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Gastrointestinal</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Belching or gas         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colitis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colon trouble           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficult digestion     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Distension of abdomen   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive hunger        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intestinal worms        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver trouble           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain over stomach       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor appetite           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting of blood       |

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|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Eyes, Ears, Nose &amp; Throat</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colds                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crossed eyes                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Deafness                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental decay                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Earache                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear discharge                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear noises                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged glands                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged thyroid                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye pain                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failing vision                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Far sightedness                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gum trouble                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nasal obstruction                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Near sightedness                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus infection                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sore throat                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis                          |

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|--------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Cardiovascular</b>        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hardening of arteries        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain over heart              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Slow heart beat              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Respiratory</b>           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficult breathing          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spitting up blood            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spitting up phlegm           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Skin</b>                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Boils                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dryness                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hives or allergy             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Itching                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin eruptions (rash)        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Genitourinary</b>         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed-wetting                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inability to control kidneys |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney infection or stones   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostrate trouble            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pus in urine                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>For Women Only</b>        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Congested breasts            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps or backache           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular cycle              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menopausal symptoms          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful menstruation         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?            |

**Check the following conditions you have had:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores     | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Whooping cough   |

# Full Body Study Questionnaire

## Complete These Diagrams

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

## Major Complaints

(Please list any condition you are being treated for or experiencing)

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## Please Show Areas of:

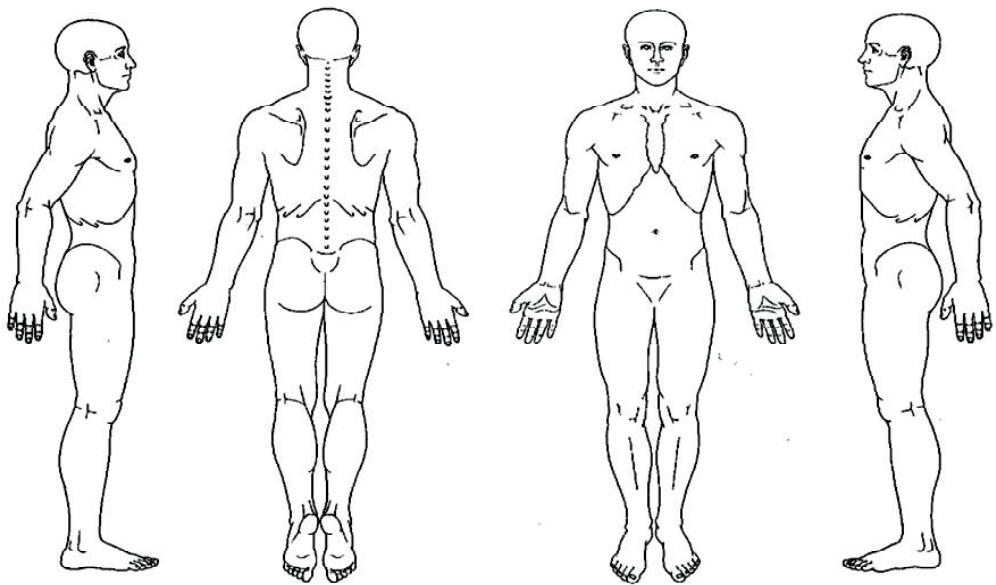
Main Pain \*

Secondary Pain O

Numbness //

Pins and Needles :::::

Skin lesions / Scarring >> >>



Do you know what triggered the pain? \_\_\_\_\_

Does anything relieve it? \_\_\_\_\_

Does anything aggravate it? \_\_\_\_\_

Has it changed since it began? \_\_\_\_\_

Have you had any treatment? \_\_\_\_\_

## History: Injuries / Fractures / Surgeries

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**INFORMATION/APPLICATION FOR CARE**

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

NAME \_\_\_\_\_ HOME # \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ MARITAL STATUS: S M W D NO. OF CHILDREN \_\_\_\_\_

**PATIENT'S INFORMATION**

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ YEARS ON JOB \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ SS # \_\_\_\_\_ DO YOU HAVE MEDICARE? YES NO

PRIMARY CARE PHYSICIAN \_\_\_\_\_

**SPOUSE'S/PARENT'S INFORMATION**

(PLEASE FILL THIS SECTION OUT IF YOU ARE NOT THE PRIMARY CARD HOLDER)

NAME OF SPOUSE/PARENT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ YEARS ON JOB \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

REFERRED TO OUR OFFICE BY: \_\_\_\_\_

**HOW PAYMENT WILL BE MADE:**

CASH \_\_\_\_\_ CHECK \_\_\_\_\_ CREDIT CARD \_\_\_\_\_  
WORKER'S COMP. \_\_\_\_\_ AUTO INS. POLICY \_\_\_\_\_ HEALTH INSURANCE \_\_\_\_\_

IS YOUR CONDITION DUE TO AN ACCIDENT? YES \_\_\_\_\_ NO \_\_\_\_\_ DATE OF ACCIDENT \_\_\_\_\_

TYPE OF ACCIDENT? AUTO \_\_\_\_\_ WORK/ON JOB \_\_\_\_\_ AT HOME \_\_\_\_\_ OTHER \_\_\_\_\_

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? PAST YEAR \_\_\_\_\_ PAST 5 YEARS \_\_\_\_\_ OVER 5 YEARS \_\_\_\_\_ NEVER \_\_\_\_\_

I (WE) AGREE TO PAY FOR SERVICES RENDERED TO ABOVE MENTIONED PATIENT AS THE CHARGE IS INCURRED. I UNDERSTAND AND AGREE THAT HEALTH & ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES COVERED OR NOT COVERED. I ALSO UNDERSTAND IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEE FOR PROFESSIONAL SERVICES RENDERED BY ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NOTICE TO OUR NEW PATIENTS: FULL PAYMENT FOR SERVICES RENDERED IS DUE AT THE END OF EACH VISIT. IF FOR ANY REASON THIS REQUEST CANNOT BE MET, ARRANGEMENTS SHOULD BE MADE IN ADVANCE BEFORE SEEING THE DOCTOR.

INSURANCE CASES: ON ALL INSURANCE ASSIGNMENTS THE DEDUCTIBLE SHOULD BE MET IN THE BEGINNING UNLESS PRIOR ARRANGEMENTS ARE MADE.