CONFIDENTIAL PATIENT CASE HISTORY

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

A. GENERAL INFORMATION

☐ **Miss** ☐ **Mrs.** ☐ **Ms.** ☐ **Mr.** How would you like to be addressed ______________________________

NAME: ____ DATE: ____

ADDRESS: ____________________________________CITY: __________________ POSTAL CODE: _________________________

Home Phone: ________________ Business Phone: ________________ Ext: _______ Cellular/other: _____________________________

Date of Birth: D/M/Y ______/______/_______ Email: ________________________________ Sex M ☐ F ☐ Age________________

Occupation or Profession: _________________________________ Employed by: ____

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of Dependents: ______________

EXTENDED COVERAGE? NO ☐ YES ☐ If yes, state policy name: ____

Referral Source: ________________________________ Family Physician: ____

About Your Health . . .

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in your lowered state of health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

B. PRESENT HEALTH: Are you presently affected by any of the following? (within past 3 months)

O – OCCASIONAL F – FREQUENT C- CONSTANT

MUSCLE AND JOINT O F C
- Backache ……….……… ☐☐☐
- Neck Pain …………….… ☐☐☐
- Painful tailbone ……..…. ☐☐☐
- Foot trouble ……………. ☐☐☐
- Shoulder pain ….………. ☐☐☐
- Hernia …………………. ☐☐☐
- Spinal curvature ………. ☐☐☐
- Faulty posture .………… ☐☐☐
- Arthritis ……..………… ☐☐☐

STRESS SYMPTOMS
- Headache/Migraine ......… ☐☐☐
- Dizziness ……………..… ☐☐☐
- Numbness or pins & needles in arms/hands, legs/feet … ☐☐☐
- Ringing in ears/tinnibus …. ☐☐☐
- Blurring of vision ………… ☐☐☐
- Loss of sleep …………….. ☐☐☐
- Loss of concentration/memory ☐☐☐
- Irritable/Nervousness ☐☐☐
- Depression ……………….. ☐☐☐
- Decreased energy/fatigue.. ☐☐☐

GENERAL SYMPTOMS O F C
- Fever/Chills/Sweat ………… ☐☐☐
- Fainting ……….………….. ☐☐☐
- Convulsions ……….……… ☐☐☐
- Allergy ……….………….. ☐☐☐
- Skin problems ….………… ☐☐☐
- Colds …………………….. ☐☐☐
- Tremors………………….. ☐☐☐
- Loss of balance .……….. ☐☐☐

RESPIRATORY
- Chronic cough ……….….. ☐☐☐
- Spitting up phlegm/blood….. ☐☐☐
- Chest pain ……………….. ☐☐☐
- Difficult breathing ………… ☐☐☐

URINARY
- Painful urination …………….. ☐☐☐
- Getting up at night to urinate ………………………☐☐☐
- Blood in urine …………………☐☐☐
- Increased urination ………….. ☐☐☐

GASTROINTENSIAL O F C
- Difficult digestion ……….. ☐☐☐
- Belching or gas ……..…. ☐☐☐
- Nausea or vomiting .….. ☐☐☐
- Pain over stomach ….... ☐☐☐
- Constipation …..……….. ☐☐☐
- Colon trouble ……….….. ☐☐☐
- Liver trouble ……….….. ☐☐☐
- Gall bladder trouble ...…. ☐☐☐
- Heartburn ………….….. ☐☐☐
- Diarrhea .……………..… ☐☐☐
- Bloody stools ………..… ☐☐☐

EYES, EARS, NOSE, THROAT
- Deafness ………………… ☐☐☐
- Earache …………………… ☐☐☐
- Sore throat ……………….. ☐☐☐
- Asthma …………………… ☐☐☐
- Tonsillitis ………………….. ☐☐☐
- Sinus trouble ……………… ☐☐☐

CARDIOVASCULAR O F C
- Rapid heart beat ………. ☐☐☐
- Slow heart beat ………... ☐☐☐
- High blood pressure ……. ☐☐☐
- Low blood pressure ….…. ☐☐☐
- Pain over heart ……….… ☐☐☐
- Swelling of ankles …....... ☐☐☐
- Previous heart attack ... Yes ☐ No ☐
- Poor circulation …….. Yes ☐ No ☐
- Previous Stroke ….…. Yes ☐ No ☐

FEMALES ONLY
- Painful menstruation…. Yes ☐ No ☐
- Excessive flow ……….. Yes ☐ No ☐
- Irregular ………………. Yes ☐ No ☐
- Cramps or backache … Yes ☐ No ☐
- Abnormal discharge …. Yes ☐ No ☐
- Passed menopause …. Yes ☐ No ☐
- Are you pregnant? …… Yes ☐ No ☐
- Birth control pill Yes ☐ No ☐
- No. of miscarriages ____________
- Date of last menstrual period ______________________

C. PAST HEALTH: Have you ever suffered from any of the following conditions?

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
Thyroid trouble ………….	☐	☐	Tuberculosis …………………	☐	☐	Emotional problems ………	☐	☐	Psoriasis ……………………	☐	☐
Diabetes …………………..	☐	☐	Pheumonia …………………..	☐	☐	Epilleptic seizures ……….	☐	☐	Polio ……………………….	☐	☐
High blood pressure …….	☐	☐	Backpain ……………………..	☐	☐	Asthma ……………………	☐	☐	Cancer ……………………..	☐	☐
Heart disease ……………..	☐	☐	Headaches …………………..	☐	☐	Arthritis ……………………	☐	☐	Venereal disease …………	☐	☐
Allergies …………………..	☐	☐	Stomach ulcers ………………	☐	☐	Alcoholism ………………...	☐	☐	H.I.V. ………………………..	☐	☐

Please Complete Next Page

Please list any significant illness, operations, accidents or falls

Date	Illness / Operations / Accidents / Falls

Sleeping Posture: ☐ Side ☐ Stomach ☐ Back / Were you taught how to care for your spine? Yes ☐ No ☐

Sports / Activities while growing up: ______________________________

Daily / Weekly activities ______________________________

CONSULTATION HISTORY

Major Complaint (if applicable) ______________________________

Have you had this problem longer than 1 week? ______ Yes ______ No How Long? ______________________________

Have you had this problem more than once in your life? ______ Yes ______ No How many times? ______________________________

What makes this problem worse? ______________________________

Have you tried anything on your own to get rid of this problem? _____ Yes _____ No Have you tried: _____ Ice; _____ Heat; _____ Stretching;

_____ Exercise; _____ Vitamins; _____ Medications; _____ Rubs or gels (mineral ice, etc.); _____ Change in diet;

_____ Aspirins/Tylenol; _____ Stress reduction? Current Medications (List) ______________________________

Can you think of any falls when you were younger (stairs, play-ground, swings, gymnastics, etc.) _____ Yes _____ No

Describe: ______________________________

Have you had any auto or work accidents in your life? _____ Yes _____ No

Describe: ______________________________

Do you do repetitive motions on the job? (Constant bending, lifting, operate machinery, phone work, computer work) _____ Yes _____ No

Please describe how it feels when this problem is at it's worst ______________________________

____

Compare this problem as it's worst and a time when you felt great. How does this problem at it's worst interfere with:

Your ability to work? ______________________________

Your ability to enjoy your family or social time? ______________________________

Your ability to enjoy your hobbies or sports? ______________________________

At its worst, how does it make you feel? ______________________________

If you don't get this problem corrected, do you think it will get worse in the next 5 years? _____ Yes _____ No

On a scale of 1 – 10, 10 being the highest, rate your commitment to correcting this problem. _________________

Do you have children? _____ Yes _____ No How many? ______ What are their names/ages: ______________________________

____

The reason we ask. . . . "The spine is the most neglected part of children's health." Do they get earaches, headaches, allergies, frequent colds (more than 4 per year), asthma, bronchitis or any other problems? ______________________________

D. INFORMED CONSENT:

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in one million. Tests, with or without x-rays, have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor.

I have read the above statement and consent to treatment.

____

Signature

Thank you for completing this form. We certainly hope we can help you attain optimal health.