FIRST CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____Birthday _____Age_____ Sex □ M □ F

Address _____City _____ State_____Zip_____

Soc. Sec. # _____Home Phone _____ Work _____

Cell _____E-Mail _____Marital Status: □ M □ S □ D □ W

Occupation _____Employer_____

Children, Ages _____Spouse's Name _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major concern? _____

_____

What do you think caused this condition? _____

How long have you had this condition? What date did it begin? _____

Have you had this or similar conditions in the past? _____

What positions or activities make it feel worse? _____

What positions or activities make it feel better? _____
Is this condition: □ Improved □ Unchanged □ Getting Worse
Is this condition interfering with your: □ Work □ Sleep □ Daily Routine □ Other_____

Other doctors or therapists who have treated THIS condition_____
For THIS condition, I have had: □ X-rays □ MRI □ CT Scan □ Other

Do you have a family physician? Name _____

List surgical operations and years: _____

_____

Have you been to a chiropractor before? _____When was your last visit? _____

Current medical conditions, medications, dosage and frequency:_____

_____

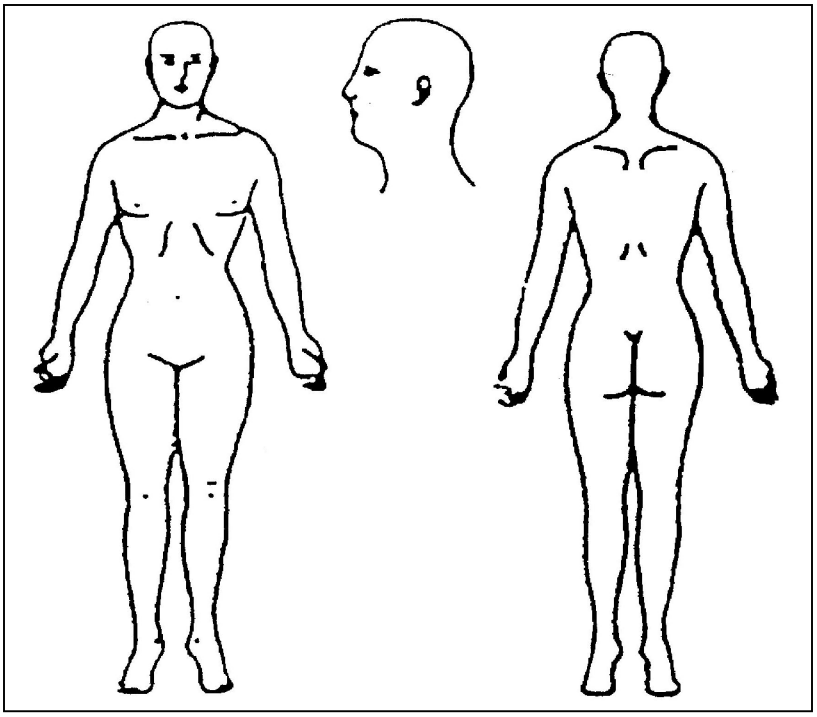
_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name_____Date_____

FIRST CHIROPRACTIC CENTER



MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE LEFT. Use the following symbols:

Aches ΛΛΛΛ
Numbness oooo
Pins/Needles □□□□
Burning xxxx
Stabbing ////

MARK AN "X" ON THE LINES:

How bad are your symptoms now?
0_____ 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ 8_____ 9_____ 10
None Most Severe

Since your symptoms started, what is the worst they have been?
0_____ 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ 8_____ 9_____ 10
None Most Severe

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

General	Now	Past	Head	Now	Past	Nose	Now	Past
Weakness	□	□	Headache	□	□	Bleeding	□	□
Fatigue	□	□	Injuries	□	□	Pain	□	□
Fever	□	□	Last Eye Exam	____	____	Discharge	□	□
Chills	□	□	Glasses	□	□	Obstruction	□	□
Night Sweats	□	□	Contacts	□	□	Post Nasal Drip	□	□
Fainting	□	□	Cataracts	□	□	Deviated Septum	□	□
Skin			**Ears**			Sinus Congestion	□	□
Mole Changes	□	□	Hard of Hearing	□	□	**Mouth**		
Rashes	□	□	Deafness	□	□	Bleeding Gums	□	□
Soreness	□	□	Ringing	□	□	Sores	□	□
			Discharge	□	□	Loss of Taste	□	□
			Earache	□	□	Dry Mouth	□	□
			Itching	□	□	Ulcers	□	□
						Blisters	□	□

Patient Name_____Date_____

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Throat	Now	Past
Soreness	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
Neck		
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
Breasts		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Bloated	☐	☐
Lungs		
Cough	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
Heart		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
Blood		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐

Gastrointestinal	Now	Past
Abdominal Pain	☐	☐
Nausea	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
Genitourinary		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Spotting Between Periods	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type_____

Age at First Period_____

No. of Pregnancies_____

No. of Births_____

No. of Miscarriages_____

No. of Abortions_____

Menstrual Flow ☐ Heavy ☐ Mod ☐ Light

Last Period_____

Last Pap Smear_____

Last Vaginal Exam_____

Last Mammogram_____

Currently pregnant? ☐ **Yes** ☐ **No**

Last Prostrate Exam_____

Neurological	Now	Past
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficult Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐
Endocrine		
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Psychiatric		
Hyperventilation	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Hallucinations	☐	☐
Alcoholism	☐	☐
Drug Dependence	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐
Musculoskeletal		
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

Patient Name_____Date_____

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Past Medical History

Hay Fever	☐	Ulcers	☐	Nervous Breakdown	☐
Mumps	☐	Jaundice	☐	Migraine	☐
Rheumatic Fever	☐	Skin Trouble	☐	Gout	☐
Angina	☐	Gallstones	☐	Hemorrhoids	☐
Cancer	☐	Liver Trouble	☐	Prostate Problems	☐
Tumor	☐	Hepatitis	☐	Sexual Problems	☐
Blood Disease	☐	Parasites	☐	Gonorrhea	☐
Leukemia	☐	Epilepsy	☐	Syphilis	☐
Heart Trouble	☐	Paralysis	☐	Diabetes	☐
Varicose Veins	☐	Polio	☐	Bladder Trouble	☐
Phlebitis	☐	Mental Illness	☐	Kidney Stones	☐
Hypertension	☐	Alcoholism	☐	Kidney Infections	☐
Stroke	☐	Depression	☐		

Allergies: _____

_____

FAMILY HISTORY

Is there any significant disease or condition present in more than one member of your family? (eg. Heart Disease, Stroke, Hypertension, Diabetes, Rheumatism)

Condition _____ Family Members _____

_____ _____

SOCIAL HISTORY

Current Height_____Current Weight_____Have you recently lost or gained weight?_____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week_____

Type_____

Smoking ☐ Current ☐ Previous Packs/Day_____ No. of Years_____

Alcohol Drinks/Week_____ No. of Years_____

Caffeine Cups/Day_____ No. of Years_____
(Coffee, Tea, Cola)

Aspirin No./Day_____ No. of Years_____

Patient Name_____Date_____