CONFIDENTIAL PATIENT CASE HISTORY Date today____________________

Name____ Birth Date___________________
Address____ Home phone __________________
City, State & Zip____ Cell phone_____________________
Social Security #____________________ Driver's License #__________________
Employer______________________ Occupation_________________________ Phone (W)______________
Sex: M____ F____ Marital Status: S__M__D__ W__
Spouse name_______________ Spouse employer___________________Spouse phone (w)______________
IN CASE OF EMERGENCY: (relative or friend not living in your home.)
Name____
Address____*Phone*_________________________

How did you hear about our office?____
Have you ever seen a Chiropractor before? yes_______ no_______
If yes, Last Chiropractic Care Date_______________ Doctor's Name________________________________
Treated for What…and the Results____
____

What is your major complaint?____
____
How long have you had this condition?____
Have you had this or similar conditions in past? (when)____
Previous diagnoses and treatments received for present condition___________________________________
____With Whom?________________________________
What aggravates your condition?____
What helps your condition?____
Is condition getting worse? Yes___ No____ Constant_____ Comes and Goes______
Is condition interfering with: Work___ Sleep___ Daily Routine___ Other_____________________________
Is this a Workman's Comp. Accident? Yes____ No____ Is this an Auto Accident? Yes____ No____
* *
Please enter: "**2**" (Had), or "**3**" (Have) in front of all of the following signs and symptoms. Leave blank if Never. A complete history and understanding of your health will help us facilitate your care.

GENERAL SYMPTOMS
_____Allergies? _________________
_____Dizziness
_____Headache
_____Loss of weight
_____Vision problems, explain

MUSCLE & JOINTS
_____Low back pain
_____Neck pain or stiffness
_____Numbness/pain in extremities:
Where?__________________________
_____Pain between shoulders

RESPIRATORY
_____Chest pain
_____Chronic cough
_____Difficulty breathing
_____Wheezing
_____Spitting blood

CARDIO-VASCULAR
_____High blood pressure
_____Low blood pressure
_____Swelling of ankles
_____Varicose veins

GENITO-URINARY
_____Bed wetting
_____Painful urination
_____Frequent urination
_____Inability to control bladder
_____Prostate problems

FOR WOMEN ONLY
Are you pregnant? Yes____ No____
Do you have children?
Yes_____ No_____
_____Problems in pregnancy?
If so, what?________________

Are you presently taking any medications (prescription or patent?) If so, what?_____

_____

List any accidents and dates: Auto_____

Sports_____ School_____

Other_____

Were you ever knocked unconscious?_____ How?_____

Have you been hospitalized?_____ Why?_____

Age of your mattress_____ Comfortable?_____ Use a bed board?_____

Do you suffer from any condition other than that for which you are consulting us?_____

_____

FAMILY HISTORY (Many health problems are the result of hereditary weaknesses, thus information about your family members will give us a better picture of your total health.)

Name	Relation	Past & Present Problem

Cancer or Diabetes in Family? List type and whom:_____

_____

PLEASE GIVE MOST CURRENT DATE AND RESULTS:

Height:_____ **Weight:**_____

Blood Test_____

Dental Exam_____

HIV Test_____

Positive_____ Negative_____

Physical Exam_____

Urine Test_____

X-ray (Types)_____

Where taken?_____

Surgeries? _____

_____

HABITS:	Heavy	Mod	Light	None
Alcohol	( )	( )	( )	( )
Appetite	( )	( )	( )	( )
Coffee	( )	( )	( )	( )
Drugs	( )	( )	( )	( )
Exercise	( )	( )	( )	( )
Tobacco	( )	( )	( )	( )
Sleep	( )	( )	( )	( )

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to the Doctor's Office will be credited to my account on 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 and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

PATIENT'S SIGNATURE X_____ Date_____