FIRST CHIROPRACTIC & WELLNESS CLINIC

Confidential Patient Case History **Date:**________________________

INITIAL INFORMATION

Name: ______________________________ **Sex:** M/F **Birth date** (mm/dd/yyyy):__________________

Email: ______________________________ **May we contact you by email?** yes/no

Height: __________ **Weight:** __________ **Occupation:**__________________________

PAST HEALTH HISTORY

Please mark the following conditions that you have presently with a check ☑ or have had in the past with an ☒.

GENERAL
- □ Allergies
- □ Weight Loss
- □ Weight Gain
- □ Skin Irritations
- □ Sweats
- □ Tremors
- □ Chills
- □ Fever

NEUROLOGICAL
- □ Convulsions
- □ Dizziness
- □ Nausea
- □ Numbness
- □ Tingling Sensation
- □ Nervousness/Depression
- □ Burning Sensation
- □ Headaches
- □ Muscle Weakness

MUSCLE AND JOINT
- □ Shoulder
- □ Mid-back pain/stiffness
- □ Knee
- □ Hip
- □ Elbow
- □ Neck pain/stiffness
- □ Ankle
- □ Spinal curvature
- □ Hand/wrist
- □ Low back pain/stiffness
- □ Foot

GENITO-URINARY
- □ Kidney stones
- □ Urinary tract infections
- □ Painful urination
- □ Frequent urination
- □ Inability to control urination

GASTROINTESTINAL
- □ Gall bladder problems
- □ Liver trouble
- □ Vomiting of blood
- □ Hernia
- □ Blood in stool
- □ Inability to control bowel

Other digestive problems (specify):

____

RESPIRATORY
- □ Chest pain
- □ Difficult breathing
- □ Spitting up blood
- □ Asthma
- □ Coughing

Other respiratory problems (specify):

____

CARDIOVASCULAR
- □ Hardening of arteries
- □ Poor circulation
- □ High blood pressure
- □ Swelling of ankles

Other cardiovascular problems (specify):

____

EYES, EARS, NOSE AND THROAT
- □ Enlarged glands
- □ Deafness/hearing loss
- □ Enlarged thyroid
- □ Trouble speaking
- □ Problems swallowing
- □ Falls due to poor balance
- □ Blurred vision

Other problems in these areas (specify):

____

FOR WOMEN ONLY
- □ Hot flashes
- □ Irregular cycle
- □ Menopausal symptoms
- □ Lumps in breasts

Are you pregnant? YES□ NO□

Other problems in these areas (specify):

____

MALE ONLY
- □ Prostate problems
- □ Sexual dysfunction
- □ Impotency

Other problems in these areas (specify):

____

OTHER (specify):

____
____
____
____
____

Circle the following conditions you presently have or have had in the past.

Alcoholism	Emphysema	Rheumatic fever	Polio	Cancer
Pneumonia	Ulcers	Gout	Anemia	Epilepsy
Stroke	Arteriosclerosis	Arthritis	Diabetes	Tuberculosis
Heart disease	Osteoporosis	Other (specify):________		

1. Have you ever been to a chiropractor before? YES ☐ NO ☐

2. Have you ever had any x-rays of your spine or neck taken? YES ☐ NO ☐ If YES, when?____________________

3. List previous diagnoses/serious illnesses you have had: ____________________

4. List any surgeries you have had: ____________________

5. Do you smoke? YES ☐ NO ☐

6. Medications you now take: ☐ Sleeping pills ☐ Pain killers ☐ Muscle relaxants ☐ Birth control pills ☐ Insulin ☐ Diuretic ☐ Antidepressants ☐ Blood thinners ☐ Anti-anxiety ☐ Other (specify): ____________________

Have you ever experienced any of the following, even short temporary attacks?

1. Blurred or double vision YES ☐ NO ☐
2. Partial or complete loss of vision YES ☐ NO ☐
3. Ringing, buzzing or noise in ear(s) YES ☐ NO ☐
4. Hearing loss in one or both ears YES ☐ NO ☐
5. Slurred speech or other speech problems YES ☐ NO ☐
6. Difficulty swallowing YES ☐ NO ☐
7. Dizziness or sudden collapse YES ☐ NO ☐
8. Lack of understanding YES ☐ NO ☐
9. Loss of consciousness YES ☐ NO ☐
10. Numbness or loss of sensation YES ☐ NO ☐

CURRENT HEALTH HISTORY

1. Briefly describe your current complaint/reason you came into the clinic: ____________________
____

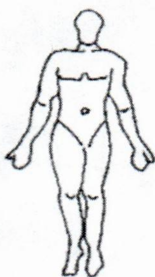
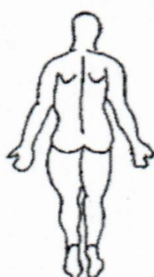
2. When did this condition begin? ____________________

3. Is the pain constant or intermittent? ____________________

4. What aggravates this condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Other____________________

5. What relieves this condition? ☐ Rest ☐ Ice ☐ Heat ☐ Medication ☐ Other____________________

6. Mark the areas on your body where you feel the described sensations. **Use appropriate symbol(s).** Include all affected areas.

LEGEND:
A = ACHE
P = PINS & NEEDLES
B = BURNING
S = STABBING
N = NUMBNESS
O = OTHER

7. Mark your level of pain right now: (0 = no pain) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (10 = worst pain)