

CONFIDENTIAL CASE HISTORY

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Name _____ Date _____

Major Complaint (s) : _____

Tests/Exams: Relative to current condition (X-ray, CT Scan, MRI, Blood Work, Etc.) _____

HABITS:	YES	NO	If yes, please describe:
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: 0 - 1/2 <input type="checkbox"/> 1/2 - 1 <input type="checkbox"/> 2 or more <input type="checkbox"/> Duration _____
Alcohol Consumption	<input type="checkbox"/>	<input type="checkbox"/>	# Drinks per day _____ Drinks per week _____
Coffee or Tea Consumption	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day _____
Other Drug Use (Street Drugs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Type _____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins and herbs.

ALLERGIES: Please list all known allergies, especially to medicines: _____

Treatment you are receiving or have received:

Medical care Chiropractic care Other _____

Do you currently or in the past have:			MALES ONLY	
Please mark all that apply:	When	# Episodes	Do you have:	
<input type="checkbox"/> Back pain or stiffness	_____	_____	<input type="checkbox"/> Changes in urine stream	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Neck pain or stiffness	_____	_____	<input type="checkbox"/> Lumps in testicles	<input type="checkbox"/> Sex concerns
<input type="checkbox"/> Shoulder pain	_____	_____	FEMALES ONLY	
<input type="checkbox"/> Hip pain	_____	_____	Do you have:	
<input type="checkbox"/> Foot pain or trouble	_____	_____	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Swollen or painful joints	_____	_____	<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Tubal infections
<input type="checkbox"/> Cold hands or feet	_____	_____	<input type="checkbox"/> Breast lumps or pain	<input type="checkbox"/> Sex concerns
<input type="checkbox"/> Numbness or pain in the arms	_____	_____	<input type="checkbox"/> Problems getting pregnant	
hands or fingers	_____	_____	Age periods began: _____	
<input type="checkbox"/> Numbness or pain in the legs	_____	_____	Number of pregnancies: _____	
feet or toes	_____	_____	Number of miscarriages: _____	
			Number of Cesarean Sections: _____	
			Type of birth control: _____	

HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENT OR WORK INJURIES EVALUATION & TREATMENT/YEAR
(Please be specific)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you currently or have you had:

Please mark all that apply

	Current/Past
More frequent urination	0 0
Pain or blood with urination	0 0
Kidney or bladder infection	0 0
Kidney stones	0 0
Recurrent abdominal pain	0 0
Ulcers	0 0
Heartburn	0 0
Swallowing problems	0 0
Hernia	0 0
Hemorrhoids	0 0

Do you currently or have you had:

Please mark all that apply

	Current/Past
Arthritis or gout	0 0
Bursitis	0 0
Fractured bones	0 0
Seizures	0 0
Tremor	0 0
Passing out	0 0
Speech problems	0 0
Trouble concentrating	0 0
Diarrhea or constipation	0 0

Do you currently or have you had:

Please mark all that apply

	Current/Past
Asthma	0 0
Eczema	0 0
Hay Fever	0 0
Sinus Problems	0 0
Diabetes	0 0
High cholesterol or triglycerides	0 0
Thyroid trouble	0 0
Liver trouble	0 0
Anemia	0 0
Bleeding or bruising tendency	0 0

Do you currently or have you had:

Please mark all that apply

	Current/Past
Sleep Problems	0 0
Disabled	0 0
Nervous tension	0 0
Irritability	0 0
Mood Swings / changes	0 0

Do you currently or have you had:

Please mark all that apply

	Current/Past
Low blood pressure	0 0
Racing, pounding heart	0 0
Ankle swelling	0 0
Lung or breathing problems	0 0
Pneumonia	0 0

Do you currently or have you had:

Please mark all the apply

	Current/Past
History of trauma	0 0
Infection	0 0
Unexplained weight loss	0 0
Unusual fatigue	0 0
Dizziness / Poor balance	0 0
Vomited blood	0 0
Bloody or black stools	0 0
Change in appetite	0 0
Fevers	0 0
Night Sweats	0 0
High blood pressure	0 0
Chest Pain	0 0
Shortness of breath	0 0
Chronic cough	0 0
Stroke	0 0
Heart disease or murmur	0 0
Loss of bowel or bladder control	0 0
Headaches	0 0
Muscle weakness or paralysis	0 0
Memory loss	0 0
Severe trauma	0 0
Direct head trauma	0 0
Lost consciousness	0 0
Poor coordination	0 0
Night pain	0 0
Difficulty Swallowing	0 0
Recent infection	0 0
History of osteoporosis	0 0
History of cancer	0 0
Difficulty breathing	0 0
Abdominal pain	0 0
Use of corticosteroids	0 0
Use of anticoagulants	0 0
Use of birth control pills	0 0
Numbness in groin (saddle anesthesia)	0 0
Loss of anal sphincter tone, fecal incontinence (bowel accidents)	0 0
Pain fails to improve with rest	0 0
Pain greater than 4 weeks	0 0
Prolonged use of corticosteroids	0 0
Intravenous drug use	0 0

Family History

Please note any family history of any of the below

Conditions and include relationship of relative to you

- Cancer _____
- Diabetes _____
- Headaches _____
- High Blood pressure _____
- Arthritis _____
- Epilepsy _____
- Heart Disease _____
- Stroke _____
- Spine or Back Disorder _____
- Multiple Sclerosis _____
- Psychological Problems _____

SERIOUS ILLNESSES: List current and past illnesses not mentioned above. (Including cancer, diabetes, etc.)

1. _____
2. _____
3. _____
4. _____

Signature _____

Date _____