CONFIDENTIAL CASE HISTORY

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			Packs per day: 0 – ½ ½ – 1 2 or more Duration________
Alcohol Consumption			# Drinks per day _______ Drinks per week_________
Coffee or Tea Consumption			Cups per day__________
Other Drug Use (Street Drugs)			______________________________
Exercise			Daily Weekly Monthly 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:

Please mark all that apply:	When	# Episodes
Back pain or stiffness	________________	________________
Neck pain or stiffness	________________	________________
Shoulder pain	________________	________________
Hip pain	________________	________________
Foot pain or trouble	________________	________________
Swollen or painful joints	________________	________________
Cold hands or feet	________________	________________
Numbness or pain in the arms hands or fingers	________________	________________
Numbness or pain in the legs feet or toes	________________	________________

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MALES ONLY

Do you have:

Changes in urine stream Prostate Trouble

Lumps in testicles Sex concerns

FEMALES ONLY

Do you have:

Menstrual problems Vaginal discharge

Abnormal bleeding Tubal infections

Breast lumps or pain Sex concerns

Problems getting pregnant

Age periods began:______________________

Number of pregnancies:___________________

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		
Pain or blood with urination		
Kidney or bladder infection		
Kidney stones		
Recurrent abdominal pain		
Ulcers		
Heartburn		
Swallowing problems		
Hernia		
Hemorrhoids		

Do you currently or have you had:
Please mark all that apply

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

Do you currently or have you had:
Please mark all that apply

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

Do you currently or have you had:
Please mark all that apply

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

Do you currently or have you had:
Please mark all that apply

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

DO YOU CURRENTLY OR HAVE YOU HAD:

PLEASE MARK ALL THAT APPLY

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

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.____ Date______
3.____
4.____Initials_____