Confidential Case History

Name _____ Date _____ SSN _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____

Phone (h)_____ (c)_____ (w)_____ Email _____

Occupation _____ Age _____ Sex _____ Height _____ Weight _____No. of Children _____

Marital Status ☐ single ☐ partner ☐ married ☐ separated ☐ divorced ☐ widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____

_____

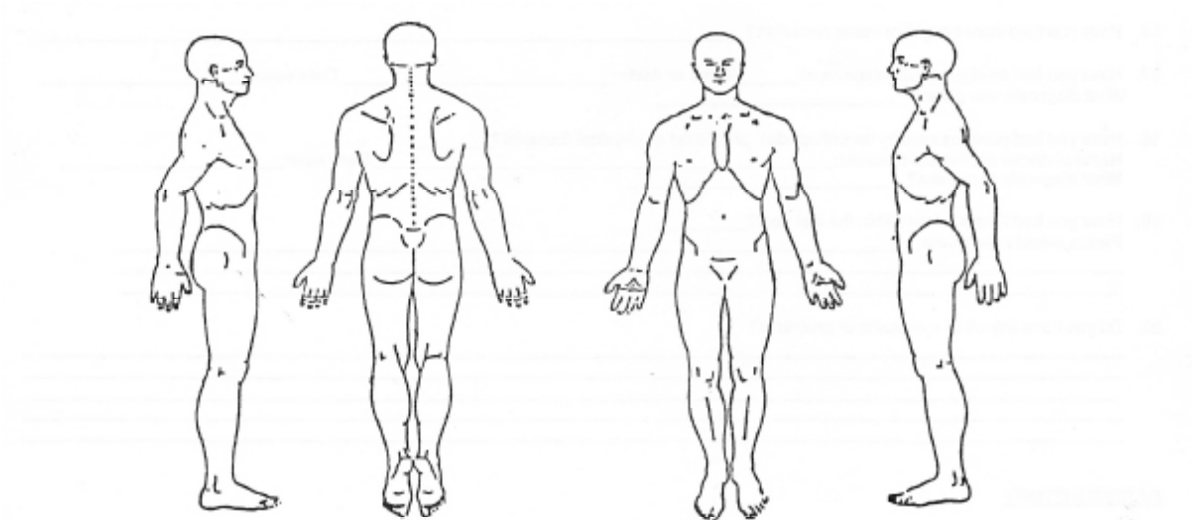
Please mark the location and course of your pain on the illustration provided. (In Adobe Acrobat, select tools from “view” in menu bar, select “comment” and open. Then select “drawing tools” in toolbar to mark diagram. This can also be completed at the time of appointment).

Additional comments:

_____

_____

_____



1. When or approximately when did it start? _____
2. Did it begin gradually of suddenly? _____
3. Did anything cause or contribute of the onset? _____
4. Have you had anything like this before? _____
5. Can you describe the exact location of your symptoms? _____

   _____
6. Does it radiate to any other part of your body? _____
7. Do you have symptoms in any other part of your body? (Describe) _____

   _____

8. Can you describe the sensation? (Dull, sharp, burning, aching, gnawing, throbbing, shooting, constricting, etc)

_____

9. Please quantify the level of pain from 1 (very mild) to 10 (severe). _____

10. Has your condition been constant or on off throughout its duration? Has it improved, worsened or stayed the same?

_____

11. Have you found anything that makes it better? (Rest, activity, morning, evening, certain positions, ice, heat, etc.)

_____

12. Have you found anything that makes it worse? (i.e. positions, activities, time of day, coughing, sneezing, straining, etc.)

_____

13. Has there been any change in bodily functions? (i.e. urination, defecation, respiration, vision, sexual, menstruation, mental clarity, etc.) _____

_____

14. Has your condition affected your daily activities in anyway? _____

_____

16. Have you had previous chiropractic care? _____ Name of doctor: _____ Date seen: _____

17. Have you had previous care by an orthopedist, physiatrist, medical doctor or physical therapist? _____

Name of doctor/ therapist: _____ Date seen: _____

Please describe: _____

_____

_____

18. Do you experience any of these symptoms every day?

☐ Debilitating fatigue	☐ Panic attacks	☐ Vomiting	☐ Low grade fever
☐ Depression	☐ Headaches	☐ Diarrhea	☐ Chronic Pain / Inflamation
☐ Disinterest in sex	☐ Dizziness	☐ Constipation	☐ Bleeding
☐ Disinterest in eating	☐ Insomnia	☐ Fecal incontinence	☐ Discharge
☐ Shortness of breath	☐ Nausea	☐ Urinary incontinence	☐ Itching / Rash

19. Do you have any other symptoms or issues?_____

_____

_____

List your current health problems and any over-the-counter or prescription medications that you are now taking.

Current health problems	Date of Onset	Current Medications

Patient History

1. Types of therapy you have tried for problem(s):

☐ diet modification ☐ fasting ☐ vitamins / minerals ☐ acupuncture

☐ herbs ☐ homepathy ☐ chiropractic ☐ conventional drugs

Other: _____

2. Have you tried store bought or home remedies? _____

3. Current health problems for which you are being treated: _____

_____

5. Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

6. Having you experienced recent changes in your ability to:

☐ see ☐ hear ☐ taste ☐ smell ☐ feel ☐ hot/ cold sensation

7. Do you use:

☐ corrective lenses ☐ dentures ☐ hearing aid ☐ other medical devices/ prosthestics/ implants

8. Have you missed time from school of work due to illness/ injury/ surgery? _____

9. Have you ever been diagnosed with having a particular condition? _____

10. Do you wear heel lifts or any other supports? _____

11. Have you had: (if yes please describe and include date of incident)

Surgeries as an adult? _____

_____

Broken any bones? _____

_____

Car accidents? _____

_____

Head trauma? _____

_____

Bad falls? _____

_____

Blows to the body? _____

_____

Sprains or strains? _____

_____

12. Do you have a strong like for the following flavors:

☐ sour ☐ bitter ☐ sweet ☐ rich/ fatty ☐ salty ☐ spicy pungent

13. Do you have a strong dislike for the following flavors:

☐ sour ☐ bitter ☐ sweet ☐ rich/ fatty ☐ salty ☐ spicy pungent

Occupation

1. Does your current job require you to primarily: (if yes, describe)
   Sit, stand, walk, other? _____
   Lifting/ Twisting? _____
   Jarring or jolting forces to the spine or extremities? (i.e. utilizing vibrating machinery, etc.) _____
   Your head to be bent forward, backward, to the side, or twisted repeatedly for extended times? _____
   Bend or twist at the waist repeatedly for extended times? _____
   Any other awkward positions? _____
2. Have you ever worked or lived somewhere where you were exposed to toxic metals, gasses, fumes, dust, radioactive materials, chemicals, or extreme temperatures? _____
3. Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactive materials, solvents)?

   _____

Life Style

1. Do you consider yourself: ☐ underweight ☐ overweight ☐ just right
2. Have you had an intentional weight loss or gain of 10 pounds of more in the last year? _____
3. Have you had an unintentional weight loss or gain of 10 pounds of more in the last year? _____
4. Do you have a balanced diet of fruits, vegetables, meat, roughage, fish, fowl, grains and dairy products? _____
5. Do you prefer a warm or cold climate/environment? _____
6. On a scale from 1 to 10, 10 being the highest, rate:
   Your overall stress level _____
   How stressful your job is _____
   How stressful your personal life is _____
   What do you consider to be be the major cause of your stress? (i.e. - spouse, family, friends, work, finances, wedding, pregnancy, legal, commute): _____
7. Do you get adequate sleep? How much? _____
8. Do you sleep well? If not, why not? _____
9. Do you sleep primarily on your back, side or stomach? _____
10. Do you read, watch TV or relax with your neck or waist bent? _____

Exercise

_____

11. How many days a week do you exercise? _____
12. How long do you generally work out for? _____
13. What kind of exercises do you generally do? (i.e. running, jogging, walking, weight lifting, swimming, biking, boxing, yoga, dance etc.)

    _____

    _____

Nutrition and Diet (which best describes your diet, check as many as apply)

☐ Mixed food diet (animal and vegetable)	*Restrictions:*	☐ eggs	☐ Total Calorie
☐ Vegan	☐ gluten	☐ soy	☐ Fat
☐ Vegetarian	☐ dairy	☐ wheat	☐ salt
☐ Paleo	☐ corn	☐ Starch/ Carbohydrate	

Eating habits

☐ Skip Breakfast	☐ Graze (small frequent meals)	☐ Eat constantly whether hungry or not	No. Meals per day: _____
☐ Food Rotation	☐ Generally eat on the run	☐ Add salt to food	

Indicate how many servings per day you eat of the following:

___ Fruits	___ Dark Greens	___ Grains (unprocessed)	___ Beans, peas, legumes
___ Yellow/orange vegetables	___ Dairy	___ Grains (processed)	___ Meat
___ Fish	___ Water (oz / day)	___ Eggs	___ Dessert

Substances

☐ Tobacco	☐ Alcohol	☐ Caffeine	☐ Other
___ Cigarettes / day	___ Wine (glasses /day)	___ Coffee (cups / day)	
___ Cigars / day	___ Liquor (oz / day)	___ Tea (cups / day)	
	___ Beers / day	___ Soda (cans / day)	

Current Supplements

☐ Multi Vitamins	☐ Vitamin C	☐ Vitamin E	☐ Fish Oil
☐ Evening Primrose/ GLA	☐ Calcium	☐ Magnesium	☐ Zinc
☐ Minerals _____	☐ Friendly flora	☐ Digestive enzymes	☐ Amino Acids
☐ CoQ10	☐ Antioxidants	☐ Herbs - teas	☐ Herbs - extracts
☐ Chinese Herbs	☐ Ayurvedic Herbs	☐ Homeopathy	☐ Bach Flowers
☐ Protein Shakes	☐ Super foods (e.g. Bee Pollen, Phytonutrient Blends)		☐ Other

Add any additional information regarding supplements here (i.e. specific minerals, calcium source etc.)

Medical

1. Date of last physical exam _____ Name of practitioner _____ Phone No. _____
2. Laboratory procedures performed (e.g. blood, saliva, and urine chemistries, stool analysis, hair analysis):

   _____

   Result: _____

   _____
3. Major hospitalizations, surgeries, injuries (list all procedures, dates, and complications if applicable)

Year	surgeries / illness / injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Have you had an MRI, Cat Scan or X-Ray(s) taken within the last year? _____ If so, please provide details _____

   _____

   _____

   _____

Medical History

☐ Arthritis	☐ Allergies	☐ Asthma	☐ Alcoholism
☐ Anxiety	☐ Alzheimer's disease	☐ Autoimmune Diseases	☐ Blood Pressure Problems
☐ Bronchitis	☐ Cancer	☐ Chronic Fatigue Syndrome	☐ Carpal Tunnel Syndrome
☐ Cholesterol, Elevated	☐ Circulatory Problems	☐ Colitis	☐ Constipation
☐ Dental Problems	☐ Depression	☐ Diabetes	☐ Diarrhea
☐ Diverticular Disease	☐ Drug Addiction	☐ Eating Disorder	☐ Epilepsy
☐ Emphysema	☐ Eyes, Ears, Nose, Throat Problems	☐ Environmental Sensitivities	☐ Flatulence
☐ Food Intolerance	☐ Gastroesophageal Reflux Disease	☐ Gout	☐ Heart Burn
☐ Heart Disease	☐ Hiatal Hernia	☐ High Fever	☐ Infection, Chronic
☐ Inflammatory Bowel Disease	☐ Irriable Bowel Syndrome	☐ Learning Disabilities	☐ Liver or Gall Bladder Disease
☐ Mental Illness	☐ Migraine Headaches	☐ Neurological Problems	☐ Obesity
☐ Osteoporosis	☐ Pneumonia	☐ Seasonal Affective Depressive Disorder	☐ Sexually Transmitted Disease
☐ Sinus Problems	☐ Skin Problems	☐ Stroke	☐ Thyroid Troubles
☐ Tuberculosis	☐ Ulcer	☐ Urinary Tract Infection	☐ Varicose Veins

☐ Other: _____

Medical (Women)

☐ Menstrual irregularity ☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts

☐ Fibroids/ovarian cysts ☐ Premenstrual Syndrome ☐ Breast Cancer ☐ Pelvic Inflammatory disease

☐ Vaginal Infections ☐ Decreased Sex Drive ☐ Pregnancy ☐ Sexually Transmitted Diseases

☐ PCOS ☐ Surgical Menopause ☐ Menopause ☐ HPV

☐ C-section ☐ HIV / AIDs ☐ Other _____

Age of first period _____

Date of late menstrual cycle _____

Length of cycle _____

Time between cycles _____

Date of last gynecological exam _____

Mammogram (positive / negative) _____

PAP (positive / negative) _____

Form of birth control _____

No. pregnancies _____

Recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

Medical (Men)

☐ Decreased Sex Drive ☐ Prostate Cancer ☐ Benign Prostatic Hyperplasia ☐ Sexually Transmitted Diseases

☐ Infertility ☐ HIV / AIDs ☐ Other: _____

Family Health History (Parents, Grandparents, Siblings)

☐ Arthritis ☐ Asthma ☐ Alcoholism ☐ Alzheimer's disease

☐ Autoimmune Disorder ☐ Cancer ☐ Dementia ☐ Depression

☐ Diabetes ☐ Drug Addition ☐ Eating Disorder ☐ Genetic Disorder

☐ Glaucoma ☐ Heart Disease ☐ Infertility ☐ Learning Disabilities

☐ Mental Illness ☐ Migraine Headaches ☐ Neurological disorders ☐ Obesity

☐ Osteoporosis ☐ Stroke ☐ Suicide Other: _____

Goals

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increased sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Get less colds and flus
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Get rid of allergies
- ☐ Stop using laxitives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Think more clearly and be more focused
- ☐ Not be dependent on over-the-counter medications (e.g. aspirin, ibuprofen, sleeping aids, antihistamines etc.)
- ☐ Reduce risk of inherited disease tendencies (e.g. cancer, heart disease, diabetes etc.)
- ☐ Be happier or more content