Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME _____ DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ S.S.No. _____

DATE OF BIRTH _____ AGE _____ M ____ F ____ MARITAL STATUS _____ No. of CHILDREN ___ EMAIL _____

OCCUPATION _____ WHERE _____ WORK PHONE _____ CELL PHONE _____

SPOUSE'S NAME _____ OCCUPATION _____ WHERE _____ REFERRED BY: _____

What is your major complaint? _____

_____

Other complaints? _____

How long have you had this condition? _____ Have you had a similar condition in the past? _____ When? _____

Have you seen anyone else for your condition? _____ Who? _____ What did they say? _____

What started your condition? _____

What activities aggravate your condition? _____ What makes it better? _____

Is this condition: ☐ getting worse ☐ getting better ☐ staying the same ☐ comes and goes

How often do you experience your present symptoms? ☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time) ☐ Occasionally (26-50% of the time) ☐ Intermittently (0-25% of the time)

Describe the nature of your symptoms. ☐ Deep ☐ Sharp ☐ Dull ☐ Stabbing ☐ Stinging ☐ Burning ☐ Throbbing ☐ Cramping ☐ Aching ☐ Pressure ☐ Shooting ☐ Tingling ☐ Numbness ☐ _____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Walking ☐ Sitting ☐ Standing ☐ Using Arms ☐ Other _____

What activities do you enjoy that your present condition makes difficult? _____

What do you believe is wrong with you? _____

How long has it been since you really felt good? _____

Indicate the average intensity of your present symptoms: (circle one) None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

How much do your symptoms interfere with your normal activity? Not at all 0 1 2 3 4 5 6 7 8 9 10 Totally disabled

Please check the appropriate box for any of the following symptoms which you now have. We want all the facts about your health before we accept your case.

THIS IS A CONFIDENTIAL HEALTH REPORT.

O = Occasional F = Frequent C = Constant

O F C GENERAL
- ☐ ☐ ☐ Dizziness/Light Headed/Fainting
- ☐ ☐ ☐ Fatigue/Exhaustion
- ☐ ☐ ☐ Common/tension headaches
- ☐ ☐ ☐ Sinus headaches
- ☐ ☐ ☐ Migraines
- ☐ ☐ ☐ Insomnia/Sleep difficulty
- ☐ ☐ ☐ Abnormal loss of weight
- ☐ ☐ ☐ Abnormal gain of weight
- ☐ ☐ ☐ Nervousness
- ☐ ☐ ☐ Irritability
- ☐ ☐ ☐ Depression
- ☐ ☐ ☐ Anxiety attacks
- ☐ ☐ ☐ Panic attacks
- ☐ ☐ ☐ Attention problems
- ☐ ☐ ☐ Pop own neck or back
- ☐ ☐ ☐ Tremors
- ☐ ☐ ☐ Marital problems

MUSCLE & JOINT
- ☐ ☐ ☐ Arthritis, where _____
- ☐ ☐ ☐ Bursitis, where _____
- ☐ ☐ ☐ Low back pain/stiffness
- ☐ ☐ ☐ Mid back pain/stiffness
- ☐ ☐ ☐ Neck pain/stiffness
- ☐ ☐ ☐ Pain across shoulders
- ☐ ☐ ☐ Pain between shoulder blades

Pain or numbness in:

		R	L
☐ ☐ ☐	Shoulders	R	L
☐ ☐ ☐	Arms	R	L
☐ ☐ ☐	Elbows	R	L
☐ ☐ ☐	Hands	R	L
☐ ☐ ☐	Hips	R	L
☐ ☐ ☐	Legs	R	L
☐ ☐ ☐	Knees	R	L
☐ ☐ ☐	Ankle	R	L
☐ ☐ ☐	Feet	R	L
☐ ☐ ☐	Jaw	R	L

- ☐ ☐ ☐ Painful tail bone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Muscle cramps, where

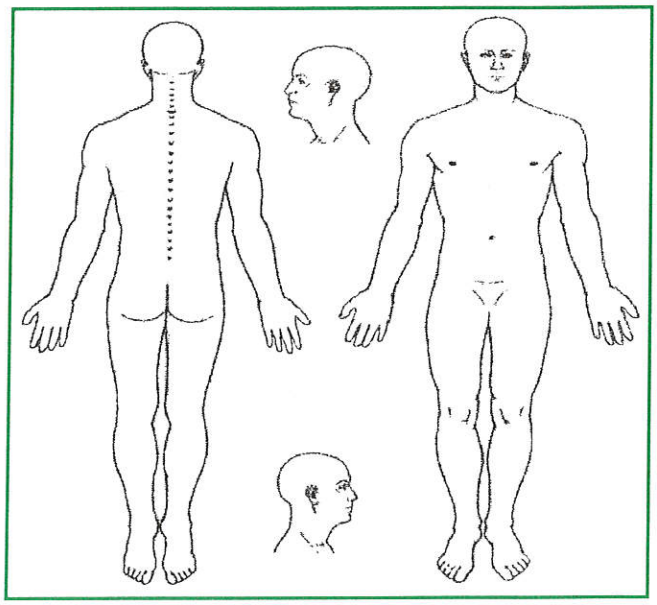
O F C GASTRO-INTESTNAL
- ☐ ☐ ☐ Belching/Gas
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Distension of abdomen/Bloating
- ☐ ☐ ☐ Hiatal hernia
- ☐ ☐ ☐ Acid Reflux
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Heart burn
- ☐ ☐ ☐ Poor appetite

E. E. N. T.
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Bronchitis
- ☐ ☐ ☐ Allergies
- ☐ ☐ ☐ Hay Fever
- ☐ ☐ ☐ Earaches
- ☐ ☐ ☐ Ear noises
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Blurred vision
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus trouble

CARDIO VASCULAR
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation, where _____
- ☐ ☐ ☐ Rapid heart beat
- ☐ ☐ ☐ Slow heart beat
- ☐ ☐ ☐ Swollen joints

RESPIRATORY
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

Outline or circle where you have symptoms.



O F CGENITO-URINARY
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Inability to control kidneys
- ☐ ☐ ☐ Kidney/Bladder infection or stones
- ☐ ☐ ☐ Painful urination

FOR WOMEN ONLY
- ☐ ☐ ☐ Breast tenderness
- ☐ ☐ ☐ Menstrual cramps or backache
- ☐ ☐ ☐ Excessive menstrual flow
- ☐ ☐ ☐ Hot flashes/ Menopausal symptoms
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Pre-menstrual syndrome (PMS)
- ☐ ☐ ☐ Mood swings

Is it possible you are pregnant? Yes No

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic fatigue syndrome
- ☐ Colitis
- ☐ Cysts
- ☐ Deafness
- ☐ Degenerative Joint(s) Disease
- ☐ Deteriating Discs
- ☐ Diabetes
- ☐ Pre Diabetes
- ☐ Drug Addiction
- ☐ Hyperactivity
- ☐ Hypoglycemia
- ☐ Eczema
- ☐ Emphysema (COPD)
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hernia
- ☐ Irritable Bowels
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Obesity
- ☐ Osteoporsis
- ☐ Overweight
- ☐ Pneumonia
- ☐ Prostate trouble
- ☐ Psoriosis
- ☐ Restless Legs
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Skin Problems
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Stenosis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Varicose veins
- ☐ Other _____

Have you ever had previous chiropractic care? _____ If yes, date of last care_____ Doctor _____

Will insurance be involved in helping to pay for your care? _____ If so, with what company?_____

Name and birthdate of policy holder_____ Place of employment_____

Is this an auto accident? ☐ Yes ☐ No Is this an Industrial Accident Case? ☐ Yes ☐ No

List surgical operations and years: _____

Drugs you now take: ☐ Antacids ☐ Pain killers ☐ Muscle relaxers ☐ Cholesterol meds
☐ Anti-depressants ☐ Diabetes meds ☐ Birth control pills ☐ Other _____

Have you ever been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Approximate Year?_____Describe _____

Have you had any other injuries or accidents? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Approximate Year?_____Describe _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No ☐ When? _____ describe _____

Have others in your family had such disorders? ☐ Yes ☐ No ☐ When? _____ describe _____

List below all conditions for which you have been treated in the past 10 years.

CONDITION	DATE	DOCTOR

DATE OF LAST:	Less than 6 mos.	Over 6 mos.	Never
Physical examination	☐	☐	☐
Spinal examination	☐	☐	☐
Blood test	☐	☐	☐
Chest x-ray	☐	☐	☐
Spinal x-ray	☐	☐	☐

What is your blood type?
A O B AB positive negative

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tea	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Energy Drinks	☐	☐	☐	☐
Artificial Sweetners	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Take Vitimans/Minerals	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

NAME_____ ADDRESS_____ PHONE _____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient_____ Date_____

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of the form. Circle your answers if your relative lives around this locality, as some heredity conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTER(S) Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ] Age [ ]
Arthritis						
Asthma - Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____

Rexroth
Chiropractic
Center