

Case History

1

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present. An understanding of your complete health history will help us to determine the appropriate care.

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Have you ever had Chiropractic care before? YES or NO

If yes, for what problem? \_\_\_\_\_

Were the results satisfactory? YES or NO What Chiropractor(s) did you see? \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_

**Review of Systems**

Do you have any of the following? (If yes, please explain)

CONDITION	NO	YES	EXPLAIN
Sinus Problems			
Chest or lung (breathing) Problems			
Heart or Blood Vessel Problems			
Digestive Problems			
Genital Problems (Prostate/Testicular/Vaginal)			
Urinary Problems (Kidney or Bladder)			
Nervous System Diseases or Mental Health Problems			
Gland or Hormone Problems			
Allergy or Immunity Problems			
Muscle, Tendon, or Ligament Problems			
Bone or Joint Diseases (examples: Osteoporosis, Arthritis)			

**FEMALES:**

CONDITION	NO	YES	EXPLAIN
Menstrual Problems			
Have you ever taken birth control pills?			For How Long?
Is there any chance that you are currently pregnant?			
Breast Problems			

**Past History**

1) List any diseases that you have had in the past, including childhood diseases: \_\_\_\_\_

2) Have you ever been diagnosed with any condition, such as diabetes, cancer, high blood pressure, AIDS, etc? If so, please

list: \_\_\_\_\_

3) Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, or broken bones? YES or NO

If yes, please explain: \_\_\_\_\_

4) List any surgeries you have had:

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Case History

2

5) Have you ever been hospitalized for any reason other than surgery? **YES** or **NO**

If yes, please explain: \_\_\_\_\_

6) Please list all **medications** (prescription and non-prescription) you are currently taking or take on an occasional basis:

\_\_\_\_\_

**Social History**

1) How many hours do you sleep each night? \_\_\_\_\_ Do you sleep continuously through the night? **YES** or **NO**

2) Do you exercise on a regular basis? **YES** or **NO** What type of exercise? \_\_\_\_\_

3) Describe your diet (*Circle one*):    Balanced      Fair      Poor      Excessive      Restricted

4) Do you smoke? **YES** or **NO** Amount per day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

5) Do you use: (*Circle all that apply*)

Caffeine      Tobacco      Alcohol      Recreational Drugs

**Additional Questions**

Please answer the following questions. If the answer is yes, please explain.

QUESTION	NO	YES	EXPLAIN
Do you have problems with recurring headaches?			
Are you losing weight without trying?			
Does your pain wake you up at night?			
Have you had a change in bowel or bladder habits?			
Have you recently had any unusual bleeding or discharge?			

1) Please add any additional information about your health history that may not have been included above:

\_\_\_\_\_

**Have you ever been diagnosed with or told you have any of the following?**

CONDITION	NO	YES	CONDITION	NO	YES
Stroke			Fractured/broken vertebra		
Herniated Disc			Bleeding disorder		
Osteoporosis			High blood pressure		
Hardening of the Arteries			Cancer		
TIA (Mini stroke)			AIDS		
Kidney Disease			Prostate Disease		

**Do you have any surgical/medical implanted devices?** **YES** or **NO** If Yes, please list: \_\_\_\_\_