CONFIDENTIAL PATIENT CASE HISTORY

FIRST NAME: _____ MIDDLE:_____ LAST:_____ CELL PHONE: _____

ADDRESS: _____ CITY:_____ STATE:_____ ZIP: _____ HOME PHONE: _____

DATE OF BIRTH:_____ AGE:_____ SS: _____ WORK PHONE: _____

M: ___ F: ___ MARITAL STATUS: _____ NO. OF CHILDREN: _____ PHONE NO. BEST TO CALL: _____

OCCUPATION: _____ REFERRED BY: _____

EMAIL ADDRESS: _____ DATE: _____ DO YOU HAVE MEDICARE _____

Please check the appropriate line for any of the following symptoms that you have now or have had previously in a significant way such that it affects your present state of health.

GENERAL:
___ Seasonal allergies
___ Food allergies
___ Convulsions
___ Dizziness
___ Fainting
___ Fatigue
___ Fever
___ Headache
___ Loss of sleep
___ Loss of weight
___ Nervousness
___ Depression
___ Neuralgia
___ Numbness
___ Sweats
___ Tremors

MUSCLES & JOINTS:
___ Arthritis
___ Bursitis
___ Foot trouble
___ Hernia
___ Low back pain
___ Neck pain or stiffness
___ Pain between shoulders
Pain or numbness in:
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___ Painful tail bone
___ Sciatica
___ Spinal Curvature
___ Swollen joints

Neurological:
__ ADD/ADHD
__ Autism Spectrum Disorder __ Age of Diagnosis

GASTRO-INTESTINAL:
___ Belching or gas
___ Colitis
___ Colon trouble
___ Constipation
___ Diarrhea
___ Difficult digestion
___ Distension of abdomen
___ Excessive hunger
___ Poor appetite
___ Gall bladder trouble
___ Hemorrhoids
___ Intestinal worms
___ Jaundice
___ Liver trouble
___ Nausea
___ Pain over stomach
___ Vomiting
___ Vomiting of blood

EYES, EARS, NOSE & THROAT
___ Asthma
___ Colds
___ Crossed eyes
___ Deafness
___ Earache/Ear Infections
___ Ear discharge
___ Ear noises – Tinnitus
___ Enlarged glands
___ Enlarged thyroid
___ Eye pain
___ Failing vision
___ Gum trouble
___ Nasal obstruction
___ Nosebleeds
___ Sinus infection
___ Sore throat
___ Tonsillitis

FOR INFANTS ONLY:
__ Spits up a lot
__ Chronic Ear Infections
__ Colic
__ Irritable/Fussy
__ Frequent Diaper Rashes

CARDIO-VASCULAR
___ High cholesterol
___ Blockage of arteries
___ High blood pressure
___ Chest pain
___ Poor circulation
___ Rapid heart beat
___ Slow heart beat
___ Swelling of ankles

RESPIRATORY
___ Chest pain
___ Chronic cough
___ Difficulty breathing
___ Spitting up blood
___ Spitting up Phlegm
___ Wheezing

SKIN
___ Boils
___ Bruise easily
___ Dryness
___ Hives or allergy
___ Itching
___ Skin eruptions

GENITO-URINARY
___ Bed-wetting
___ Blood in urine
___ Frequent urination
___ Kidney infection or stones
___ Painful urination
___ Prostate trouble

FOR WOMEN ONLY:
___ Fibrocystic breasts
___ Infertility
___ Excessive menstrual flow
___ Hot flashes/ night sweats
___ Irregular cycle
___ Menopausal symptoms
___ Painful menstruation/ cramping
___ Vaginal discharge
___ Yes ___ No Are you pregnant

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

__ Alcoholism
__ Anemia
__ Appendicitis
__ Arteriosclerosis
__ Arthritis
__ Cancer
__ Chorea
__ Cold sores
__ Diabetes
__ Diphtheria
__ Eczema
__ Emphysema
__ Epilepsy
__ Fever blisters
__ Goiter
__ Gout
__ HIV positive
__ Heart disease
__ Influenza
__ Malaria
__ Measles
__ Miscarriage
__ Multiple sclerosis
__ Mumps
__ Pleurisy
__ Pneumonia
__ Polio
__ Psoriasis
__ Rheumatic fever
__ Scarlet fever
__ Stroke
__ Tuberculosis
__ Typhoid fever
__ Ulcers
__ Venereal Disease
__ Whooping cough

Have you ever had previous chiropractic care? _____ If yes, with whom? _____ Last date of care? _____

914 Hemsath, Suite 104A, St. Charles, MO 63303 Ph: 636-724-5757

CONFIDENTIAL PATIENT CASE HISTORY

What is your major complaint?

_____

_____

Other complaints_____

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

What activities aggravate your condition? _____

Is this condition getting progressively worse? __ Yes __ No __ Constant __ Comes and goes

Is this condition interfering with your: __ Work __ Sleep __ Daily routine Other _____

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

List previous diagnoses and treatments you have received for present condition _____

_____

What do you believe is wrong with you? _____

List surgical operations and years: _____

_____

Drugs you now take: __ Anti depressants __ Anti anxiety __ Pain killers __ Muscle relaxers __ Tranquilizers __ Birth control pills __ Sleeping Pills

Others: _____

Dental visits: __Every six months __ Yearly __ Toothache or emergency only __ Complete dentures

Are you wearing: __ Heel lifts __ Arch supports __ Orthotics

Have you been in an auto accident: __ Past year __ Past five years __ Over five years __ Never

Describe: _____

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

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

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	___	___	_____
Used a cane, crutch, or other support?	___	___	_____
Been treated for a spine or nerve disorder?	___	___	_____
Had a fractured bone?	___	___	_____
Been hospitalized for other than surgery?	___	___	_____

DO YOU:			
Now take vitamins or minerals?	___	___	_____
Think you may need vitamins or minerals?	___	___	_____
Have an allergy to any drug?	___	___	_____

DATE OF LAST:	Less than 6 Months	6 – 18 Months	Over 18 Months	Never
Spinal examination				
Physical examination				
Blood test				
Chest X-Ray				
Spinal X-Ray				
Dental X-Ray				
Urine test				

HABITS	Heavy	Moderate	Light	None	Describe Briefly
Alcohol	____	____	____	____	_____
Coffee	____	____	____	____	_____
Tobacco	____	____	____	____	_____
Drugs	____	____	____	____	_____
Exercise	____	____	____	____	_____
Sleep	____	____	____	____	_____
Appetite	____	____	____	____	_____

IN CASE OF EMERGENCY, CONTACT:

NAME: _____ PHONE(S):_____

RELATION TO SELF: _____

914 Hemsath, Suite 104A, St. Charles, MO 63303 Ph: 636-724-5757