

# CASE HISTORY

Date \_\_\_\_\_

Case Number \_\_\_\_\_

Patient \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ Number of children \_\_\_\_\_ Chief complaint \_\_\_\_\_

Past chiropractic care \_\_\_ Dr's name \_\_\_\_\_ Results \_\_\_\_\_

Please check the symptoms you have experienced in the past three months.

## GENERAL SYMPTOMS

- Headache
- Fever
- Chills
- Night Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Loss of Weight
- Numbness or Pain  
arms/ legs/ hands
- Allergy (what?)
- Wheezing
- Neuralgia

## GASTRO-INTESTINAL

- Poor Appetite
- Poor Digestion
- Excessive Hunger
- Belching or Gas
- Nausea
- Vomiting
- Vomiting Blood
- Pain Over Stomach
- Constipation
- Diarrhea
- Colon Trouble
- Hemorrhoids
- Liver Trouble
- Jaundice
- Gall Bladder Trouble

## EYE, EAR, NOSE, THROAT

- Poor Vision
- Crossed Eyes
- Pain in Eyes
- Deafness
- Earache
- Ear Noises
- Ear Discharges
- Nasal Obstruction
- Nose Bleeds
- Sore Throat
- Hay Fever
- Hoarseness
- Asthma
- Frequent Colds
- Enlarged Thyroid
- Tonsillitis
- Sinus Trouble

## RESPIRATORY

- Chronic Cough
- Spitting Blood
- Spitting Phlem
- Chest Pain
- Difficulty Breathing

## Genito-Urinary

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Infection
- Bed Wetting
- Inability to control urine
- Prostrate Trouble

## EXERCISE

- None
- Moderate
- Daily

## HABITS

- Smoking \_\_\_ Packs/ Day
- Coffee \_\_\_ Cups/ Day
- Alcohol \_\_\_ Times/ Week

## MUSCLE & JOINTS

- Weakness
- Twitching
- Stiff Neck
- Backache
- Swollen Joints
- Tremors
- Foot Trouble
- Painful Tail Bone
- Hernia
- Spinal Curvature

## SKIN OR ALLERGIES

- Skin Eruptions
- Itching
- Bruising Easily
- Dryness
- Boils
- Sensitive Skin
- Hives or Allergy
- Eczema

## CARDIO-VASCULAR

- Rapid Heart
- Slow Heart
- High Blood Pressure
- Low Blood Pressure
- Pain Over Heart
- Prev. Heart Trouble
- Swelling of Ankles
- Poor Circulation
- Varicose Veins
- Strokes

## FOR WOMEN ONLY

- Painful Periods
- Excessive Flow
- Irregular Cycles
- Hot Flashes
- Cramps or Backache
- Miscarriage
- Vaginal Discharge
- Pregnant at this time
- Last Pap  
Date \_\_\_\_\_
- By Whom \_\_\_\_\_
- Last Period \_\_\_\_\_

**FAMILY HISTORY**

	Diabetes	Heart	Kidney	Cancer	Back
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother No. of _____	_____	_____	_____	_____	_____
Sister No. of _____	_____	_____	_____	_____	_____

**HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?**

- |  |                                      |   |  |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Anemia      | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Arthritis       |
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Measles     | <input type="checkbox"/> Goiter             | <input type="checkbox"/> Epilepsy        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Influenza          | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Lumbago         |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Eczema          |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer      | <input type="checkbox"/> Venereal Infection |  |

**OPERATIONS AND PROCEDURES**

- |                           |                      |               |
|---------------------------|----------------------|---------------|
| Vaccinations _____        | Tubes in Ears _____  | Sinus _____   |
| Tonsillectomy _____       | Appendectomy _____   | Hernia _____  |
| Gall Bladder _____        | Female Organs _____  | Thyroid _____ |
| Back Operation _____      | Rectal Surgery _____ | Stomach _____ |
| Other/Date and type _____ |                      |               |

**ACCIDENTS OR FALLS**

	Date	Please Explain
Car	_____	_____
Motorcycle	_____	_____
School	_____	_____
Work	_____	_____
Other	_____	_____
Broken Bones	_____	_____
Fractures	_____	_____
Dislocations	_____	_____

- Have you ever had any spinal taps or spinal injections? \_\_\_\_\_
- Have you ever been knocked unconscious? \_\_\_\_\_
- Have you ever had a lapse of memory? \_\_\_\_\_

Please list any medication you are presently taking and for what condition you are taking them.

\_\_\_\_\_

\_\_\_\_\_

Have you had x-rays taken in the past year? \_\_\_\_\_

For what condition? \_\_\_\_\_

Are you now or have you ever been disabled from work? \_\_\_\_\_