



CONFIDENTIAL PATIENT CASE HISTORY

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

Dear Patient: please complete this questionnaire. Your answers will help us determine if chiropractic can help you. Thank You.

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_ Gender: M F Marital Status: (S, M, W, D) Spouses Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_@\_\_\_\_\_

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

Do you have insurance?  Yes  No Insurance Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

How did you hear about Progressive Life? \_\_\_\_\_ Person responsible for this account: \_\_\_\_\_

History of Present Injury/Illness: Please list below the complaint(s) you have in order of importance, also the length of time you had these complaint(s).

- 1. \_\_\_\_\_ How Long? \_\_\_\_\_
2. \_\_\_\_\_ How Long? \_\_\_\_\_
3. \_\_\_\_\_ How Long? \_\_\_\_\_

Is your condition related to an accident?  Yes  No If yes describe: \_\_\_\_\_

Ever had a similar episode before?  Yes  No Describe your condition:  getting worse  the same  getting better  constant  comes & goes

What activities aggravate your condition? \_\_\_\_\_ What makes your condition better? \_\_\_\_\_

Is this condition interfering with your:  Work  Sleep  Daily routine  Other: \_\_\_\_\_

Have you seen any other health care provider for your present condition?  Yes  No Who? \_\_\_\_\_

List previous diagnoses and treatments you have received for your present condition? \_\_\_\_\_

List all medications you presently take: \_\_\_\_\_

Past History: List any surgeries you have had

- 1. \_\_\_\_\_ Date: \_\_\_\_\_ 3. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_ 4. \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever been involved in a motor vehicle accident?  Past year  Past five years  Over five year's  Never

Describe: \_\_\_\_\_

Table with 4 columns: Question, Yes, No, Describe Briefly. Rows include: Been knocked unconscious?, Used a crutch, cane, or other support?, Been treated for a spine or nerve disorder?, Had a fracture or broken bone?, Hospitalized other than surgery?

Do you: Take vitamins, minerals, or herbs?  Yes  No
Take supplements?  Yes  No

Table with 6 columns: Habits, Heavy, Moderate, Light, None, Comments. Rows include: Alcohol, Tobacco, Drugs, Exercise, Appetite

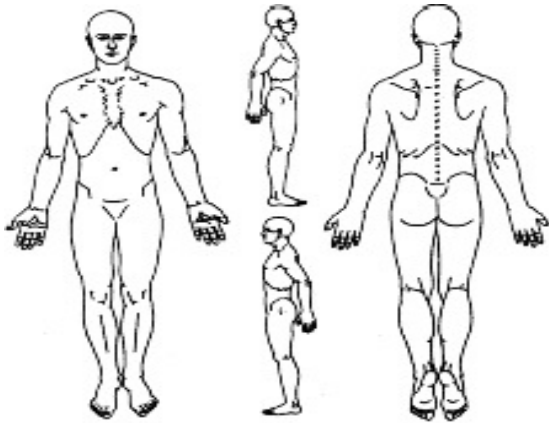
In case of an emergency who should we contact?

#1 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

#2 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## CONFIDENTIAL PATIENT CASE HISTORY

Please check the appropriate box for any of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. This is a confidential health report.



On the drawing to the left, circle the area(s) where you have pain. Then, *for each area that you have circled*, designate a number from 0 to 10 (with 10 being the most pain) that corresponds to your **current** pain level.

0-10	Burning	Sharp	Numb	Tingling	Ache	Other
___ Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Low back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P – Previous C – Current

- P C**
- General**
- Allergy / Hay fever
  - Convulsions / Tremors
  - Dizziness
  - Depression / Anxiety
  - Fainting
  - Fatigue
  - Insomnia
  - Loss of Weight
  - Night Sweats
- Muscle & Joint**
- Arthritis
  - Bursitis / Swollen Joints
  - Night Pain
  - Muscle cramps at night
  - Muscle weakness
  - Scoliosis
  - Stiffness
  - Surgical implant

- P C**
- Gastro-Intestinal**
- Belching or gas
  - Bloating after meals
  - Constipation / Diarrhea
  - Gall bladder removed
  - Colitis
- EENT**
- Deviated septum
  - Frequent colds / ear infections
  - Nosebleeds
  - Tinnitus (ringing in ears)
- Endocrine**
- Afternoon headaches
  - Crave salt
  - Coarse or thinning hair
  - Get "shaky" if hungry
  - Inability to concentrate
  - Increase in weight
  - Sensitive to cold
- Skin**
- Bruise easily
  - Hives / rash

- P C**
- Cardio-Vascular**
- Asthma
  - Chest Pain
  - Chronic cough
  - Difficulty breathing / Wheezing
  - Hardening of arteries
  - High / Low blood pressure
  - Pain over heart / chest pain
  - Spitting up blood / phlegm
  - Swelling of ankles
- Genito-urinary**
- Bed-wetting
  - Unable to control kidneys
  - Painful urination
  - Frequent urination
  - Prostate trouble
- For Women Only**
- Hot flashes
  - Irregular / Painful / Excessive menses
  - Painful breasts
  - Premenstrual tension
- Yes  No Are you pregnant?

**Family History: Check the following condition that applies for you, mother, and father**

	You	Mother	Father	explain
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Pace maker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

(Signs/Symptoms of stroke include: dizziness, one sided numbness/tingling, muscle weakness or face drooping, trouble swallowing or speaking, "worst headache ever" pain, double vision)

- I have read the Consent to Treatment for chiropractic and I have freely decided to undergo the recommended treatment.
- I allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I've been informed and understand my rights concerning HIPPA Notice of Privacy Practices, and Use and Disclosure of Protected Health Information. (Once information is disclosed, it may not be protected by law.)
- I give this office authorization to use my name for any in-office publications.
- Authorization may be denied or retracted at any time by notifying the office manager.
- I authorize payment of medical benefits to this office.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Authorization expires 3 years from above date)