

# INTRODUCTION PATIENT CASE HISTORY

Patient No: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Mr. Mrs. Miss Ms.) \_\_\_\_\_  
(Last, First, MI)

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

Home Phone: ( ) \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_

Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of your Insurance Company: \_\_\_\_\_

Primary Insurance Holder: \_\_\_\_\_ Primary Holders Date of Birth: \_\_\_\_\_

Previous Chiropractic Care? Yes No Doctor's Name: \_\_\_\_\_

Major Complaint: \_\_\_\_\_ Began When and How \_\_\_\_\_

Any Recent Surgeries \_\_\_\_\_ Any Recent Accident's \_\_\_\_\_

Medications \_\_\_\_\_ Allergies RX \_\_\_\_\_

Physicians Contact \_\_\_\_\_

Who (or what source) referred you? \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

# HEALTH ANALYSIS

Date \_\_\_\_\_

Patient \_\_\_\_\_ Address \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Separated  Divorced

Education:  High School  Some College  College Grad  Post Grad Studies  Full Time  Part Time

Age \_\_\_\_\_ Occupation \_\_\_\_\_ Recreational Activities \_\_\_\_\_

*Please Circle the Appropriate Answer.*

1. Do you need glasses to read? .....Yes No
2. Do you need glasses to see things at a distance? .....Yes No
3. Has your eyesight often blacked out completely? .....Yes No
4. Do your eyes continually blink or water? .....Yes No
5. Do you often have bad pains in your eyes? .....Yes No
6. Are your eyes often red or inflamed? .....Yes No
7. Are you hard of hearing? .....Yes No
8. Have you ever had a fluid leaking from your ear? .....Yes No
9. Do you have constant noises in your ears?.....Yes No
10. Do you have to clear your throat constantly? .....Yes No
11. Do you often feel a choking lump in your throat? .....Yes No
12. Are you often troubled with bad spells of sneezing? .....Yes No
13. Is your nose continually stuffed up? .....Yes No
14. Do you suffer from a constantly running nose? .....Yes No
15. Have you at times had bad nose bleeds? .....Yes No
16. Do you often catch severe colds? .....Yes No
17. Do you frequently suffer from heavy chest colds? .....Yes No
18. When you catch a cold, do you always have to go to bed? .....Yes No
19. Do frequent colds keep you miserable all winter? .....Yes No
20. Do you get hay fever? .....Yes No
21. Do you suffer from asthma? .....Yes No
22. Are you troubled by constant coughing? .....Yes No
23. Have you ever coughed up blood? .....Yes No
24. Do you wake up drenched with sweat during the middle of the night? .....Yes No
25. Have you ever had a chronic chest condition? .....Yes No
26. Have you ever had T.B. (tuberculosis)? .....Yes No
27. Did you ever live with anyone who had T.B.?.....Yes No
28. Has a doctor ever said your blood pressure was too high? .....Yes No
29. Has a doctor ever said your blood pressure was too low? .....Yes No
30. Do you have pains in the heart or chest? .....Yes No
31. Are you often bothered by thumping of the heart? .....Yes No
32. Does your heart often race like mad? .....Yes No
33. Do you often have difficulty in breathing? .....Yes No
34. Do you get out of breath before anyone else? .....Yes No
35. Do you sometimes get out of breath just sitting still? .....Yes No
36. Are your ankles often badly swollen? .....Yes No
37. Do cold hands or feet trouble you, even in hot weather? .....Yes No
38. Do you suffer from frequent cramps in your legs? .....Yes No
39. Has a doctor ever said you had heart trouble? .....Yes No
40. Does heart trouble run in your family?.....Yes No
41. Have you lost more than half your teeth? .....Yes No
42. Are you troubled by bleeding gums? .....Yes No

- |                                                                                  |     |    |
|----------------------------------------------------------------------------------|-----|----|
| 43. Have you often had sever tooth aches? .....                                  | Yes | No |
| 44. Is your tongue usually badly coated? .....                                   | Yes | No |
| 45. Is your appetite always poor? .....                                          | Yes | No |
| 46. Do you usually eat sweets or other foods between meals? .....                | Yes | No |
| 47. Do you always gulp your food hurriedly? .....                                | Yes | No |
| 48. Do you often suffer from an upset stomach? .....                             | Yes | No |
| 49. Do you usually feel bloated after eating? .....                              | Yes | No |
| 50. Do you usually belch a lot after eating? .....                               | Yes | No |
| 51. Are you often sick at your stomach? .....                                    | Yes | No |
| 52. Do you suffer from sever indigestion? .....                                  | Yes | No |
| 53. Do severe pains in the stomach often cause you to double up? .....           | Yes | No |
| 54. Do you suffer from constant stomach trouble? .....                           | Yes | No |
| 55. Does stomach trouble run in your family? .....                               | Yes | No |
| 56. Has a doctor ever said you had stomach ulcers? .....                         | Yes | No |
| 57. Do you suffer from frequent loose bowel movements? .....                     | Yes | No |
| 58. Have you ever had severe bloody diarrhea? .....                              | Yes | No |
| 59. Were you ever troubled with intestinal worms? .....                          | Yes | No |
| 60. Do you constantly suffer from bad constipation? .....                        | Yes | No |
| 61. Have you ever had piles (rectal hemorrhoids)? .....                          | Yes | No |
| 62. Have you ever had jaundice (yellow eyes and skin)? .....                     | Yes | No |
| 63. <u>Have you ever had serious liver or gall bladder trouble? .....</u>        | Yes | No |
| 64. Are your joints often painfully swollen? .....                               | Yes | No |
| 65. Do your muscles and joints constantly feel stiff? .....                      | Yes | No |
| 66. Do you usually have severe pains in the arms or legs? .....                  | Yes | No |
| 67. Are you crippled with severe arthritis? .....                                | Yes | No |
| 68. Does arthritis run in your family? .....                                     | Yes | No |
| 69. Do weak or painful feet make your life miserable? .....                      | Yes | No |
| 70. Do pains in the back make it hard for you to keep up with your work? .....   | Yes | No |
| 71. <u>Are you troubled with a serious bodily disability or deformity?.....</u>  | Yes | No |
| 72. Do you have sensitive skin? .....                                            | Yes | No |
| 73. Does it take a long time for a cut to heal? .....                            | Yes | No |
| 74. Does your face often get badly flushed? .....                                | Yes | No |
| 75. Do you sweat a great deal, even in cold weather? .....                       | Yes | No |
| 76. Are you often bothered by severe itching? .....                              | Yes | No |
| 77. Does your skin often break out in a rash? .....                              | Yes | No |
| 78. <u>Are you often troubled with boils?.....</u>                               | Yes | No |
| 79. Do you suffer from frequent severe headaches? .....                          | Yes | No |
| 80. Does pressure or pain in the head often make life miserable? .....           | Yes | No |
| 81. Are headaches common in your family? .....                                   | Yes | No |
| 82. Do you have hot or cold spells? .....                                        | Yes | No |
| 83. Do you often have spells of severe dizziness? .....                          | Yes | No |
| 84. Do you frequently feel faint? .....                                          | Yes | No |
| 85. Have you fainted more than twice in your life? .....                         | Yes | No |
| 86. Do you have constant numbness or tingling in any part of your body? .....    | Yes | No |
| 87. Was any part of your body paralyzed? .....                                   | Yes | No |
| 88. Were you ever knocked unconscious? .....                                     | Yes | No |
| 89. Have you at times had a twitching of the head, face or shoulders? .....      | Yes | No |
| 90. Did you ever have a seizure or convulsions (epilepsy)? .....                 | Yes | No |
| 91. Has anyone in your family ever had seizures or convulsions (epilepsy)? ..... | Yes | No |
| 92. Do you bite your nails? .....                                                | Yes | No |
| 93. Are you troubled by stuttering or stammering? .....                          | Yes | No |
| 94. Are you a sleep walker? .....                                                | Yes | No |
| 95. Are you a bed wetter? .....                                                  | Yes | No |
| 96. Were you a bed wetter between the ages of 8 to 14? .....                     | Yes | No |

### **Women Only... Are you Pregnant? Yes No**

97. W. Have your menstrual periods usually been painful? .....	Yes	No
98. W. Have you often felt weak or sick with your periods? .....	Yes	No
99. W. Have you often had to lie down when your periods came on? .....	Yes	No
100.W. Have you usually been tense or jumpy with your periods? .....	Yes	No
101.W. Have you ever had severe hot flashes or sweats? .....	Yes	No
<u>102.W. Have you ever been troubled with a vaginal discharge?.....</u>	<u>Yes</u>	<u>No</u>

### **Men only...**

97. M. Have you ever had anything wrong with your genitals? .....	Yes	No
98.M. Are your genitals often painful or sore? .....	Yes	No
99.M. Have you ever had treatment for your genitals? .....	Yes	No
100.M. Has a doctor ever said you had a hernia (rupture)? .....	Yes	No
101.M. Have you ever passed blood while urinating? .....	Yes	No
<u>102.M. Do you have trouble starting your stream when urinating?.....</u>	<u>Yes</u>	<u>No</u>

### **Everyone...**

103. Do you have to get up every night and urinate? .....	Yes	No
104. During the day, do you usually have to urinate frequently? .....	Yes	No
105. Do you have severe burning when you urinate? .....	Yes	No
106. Do you sometimes lose control of your bladder? .....	Yes	No
<u>107. Has a doctor ever said you had kidney or bladder disease?.....</u>	<u>Yes</u>	<u>No</u>
108. Are you often exhausted or fatigued? .....	Yes	No
109. Does working tire you out completely? .....	Yes	No
110. Do you usually get up tired or exhausted in the morning? .....	Yes	No
111. Does every little effort wear you out? .....	Yes	No
112. Are you constantly too tired and exhausted even to eat? .....	Yes	No
113. Do you suffer from severe nervous exhaustion? .....	Yes	No
<u>114. Does nervous exhaustion run in your family?.....</u>	<u>Yes</u>	<u>No</u>
115. Are you frequently ill? .....	Yes	No
116. Are you frequently confined to bed by illness? .....	Yes	No
117. Are you always in poor health? .....	Yes	No
118. Are you considered a sickly person? .....	Yes	No
119. Do you come from a sickly family? .....	Yes	No
120. Do severe pains and aches make it impossible for you to do your work? .....	Yes	No
121. Do you wear yourself out worrying about work? .....	Yes	No
122. Are you always ill and unhappy? .....	Yes	No
<u>123. Are you constantly made miserable by poor health?.....</u>	<u>Yes</u>	<u>No</u>
124. Did you ever have scarlet fever? .....	Yes	No
125. As a child, did you have rheumatic fever, growing pains, or twitching of the limbs? .....	Yes	No
126. Did you ever have malaria? .....	Yes	No
127. Were you ever treated for severe anemia? .....	Yes	No
128. Were you ever treated for venereal disease? .....	Yes	No
129. Do you have diabetes? .....	Yes	No
130. Did a doctor ever say you had a goiter in your neck? .....	Yes	No
131. Did a doctor ever treat you for a tumor or cancer? .....	Yes	No
132. Do you suffer from any chronic disease? .....	Yes	No
133. Are you definitely underweight? .....	Yes	No
134. Are you definitely overweight? .....	Yes	No
135. Did a doctor ever say you had varicose veins (swollen veins) in your legs? .....	Yes	No
136. Did you ever have a serious operation? .....	Yes	No
137. Did you ever have a serious injury? .....	Yes	No
<u>138. Do you often have small accidents or injuries?.....</u>	<u>Yes</u>	<u>No</u>
139. Do you usually have difficulty falling asleep or staying asleep? .....	Yes	No
140. Do you find it impossible to take a regular rest period each day? .....	Yes	No
141. Do you find it difficult to exercise daily? .....	Yes	No

142. Do you smoke more than 20 cigarettes a day? ..... Yes No
143. Do you drink more than six cups of coffee or tea a day? ..... Yes No
144. Do you usually take two or more alcoholic drinks a day? ..... Yes No
145. Do you sweat or tremble a lot during examinations or questioning? ..... Yes No
146. Do you get nervous and shaky when approached by a superior? ..... Yes No
147. Does your work fall to pieces when the boss or a superior is watching you? ..... Yes No
148. Does your thinking get completely mixed up when you have to do things quickly? ..... Yes No
149. Must you do things slowly to do them without mistakes? ..... Yes No
150. Do you always get directions and orders wrong? ..... Yes No
151. Are you anxious around unfamiliar people or places? ..... Yes No
152. Are you scared to be alone when there are no friends around you? ..... Yes No
153. Is it difficult for you to make up your mind? ..... Yes No
154. Do you always wish you had someone at your side to advise you? ..... Yes No
155. Are you considered a clumsy person? ..... Yes No
156. Does it bother you to eat anywhere except in your home?..... Yes No
157. Do you feel alone and sad at a party? ..... Yes No
158. Do you usually feel unhappy and depressed? ..... Yes No
159. Do you often cry? ..... Yes No
160. Are you always miserable and blue? ..... Yes No
161. Does life look entirely hopeless? ..... Yes No
162. Do you often wish you were dead and away from it all? ..... Yes No
163. Does worrying continually get you down? ..... Yes No
164. Does worrying run in your family? ..... Yes No
165. Does every little thing get on your nerves and wear you out? ..... Yes No
166. Are you considered a nervous person? ..... Yes No
167. Does nervousness run in your family? ..... Yes No
168. Did you ever have a nervous breakdown? ..... Yes No
169. Did anyone in your family ever have a nervous breakdown? ..... Yes No
170. Were you ever a patient in a mental hospital? ..... Yes No
171. Was anyone in your family ever in a mental hospital?..... Yes No
172. Are you extremely shy or sensitive? ..... Yes No
173. Do you have a shy or sensitive family? ..... Yes No
174. Are your feelings easily hurt? ..... Yes No
175. Does criticism always hurt you? ..... Yes No
176. Are you considered a touchy person? ..... Yes No
177. Do people usually misunderstand you?..... Yes No
178. Is your guard up, even around friends? ..... Yes No
179. Do you always do things on sudden impulse? ..... Yes No
180. Are you easily upset or irritated? ..... Yes No
181. Do you go to pieces if you don't constantly control yourself? ..... Yes No
182. Do little annoyances get on your nerves and get you angry? ..... Yes No
183. Does it make you angry to have anyone tell you what to do? ..... Yes No
184. Do people often annoy and irritate you? ..... Yes No
185. Do you often flare up in anger if you can't have what you want right away?..... Yes No
186. Do you often get in a violent rage?..... Yes No
187. Do you often shake or tremble? ..... Yes No
188. Are you constantly keyed up or jittery? ..... Yes No
189. Do sudden noises make you jump or shake? ..... Yes No
190. Do you tremble or feel weak whenever someone shouts at you? ..... Yes No
191. Do you become scared at sudden movements or noises at night? ..... Yes No
192. Are you awakened out of your sleep by frightening dreams? .. Yes No
193. Do frightening thoughts keep coming back in your mind? ..... Yes No
194. Do you often become frightened for no apparent reason? ..... Yes No

\*Grade Intensity/Severity: (No complaint or pain) 0 1 2 3 4 5 6 7 8 9 10 (Worse possible pain/complaint imaginable)