Confidential Patient Case History

Name _____ Date _____

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

Please check the box if you have experienced any of the following:

GENERAL
- ☐ Allergy
- ☐ Chills
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness/depression
- ☐ Neuralgia
- ☐ Numbness
- ☐ Sweats
- ☐ Tremors

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Hernia
- ☐ Low back pain
- ☐ Lumbago
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders

Pain or numbness in:
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Painful tail bone
- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Swollen joints

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

EYES, EARS, NOSE & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Crossed eyes
- ☐ Deafness
- ☐ Dental Decay
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far sightedness
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Near sightedness
- ☐ Nosebleeds
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis

CARDIO-VASCULAR
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

SKIN
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

GENITO-UNRINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Inability to control kidneys
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Pus in urine

FOR WOMEN ONLY
- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Yes ☐ No Are you pregnant?

Name_____ Date_____

CHECK THE FOLLOWING CONDITION YOU HAVE HAD:

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

List current medications: _____

_____

List current vitamins/supplements: _____

_____

Are you allergic to any medications? List: _____

List surgical operation and years: _____

_____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable

Do you wear orthotics? ☐ Yes ☐ No

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? _____

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 anything other than surgery	☐	☐	_____

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	☐	☐	☐	☐
MRI/CAT Scan	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐