CONFIDENTIAL CLIENT HISTORY

NAME________________________DATE__________HOME PHONE______________

ADDRESS____________________CITY______________STATE_______ZIP______________

DATE OF BIRTH____________ AGE_____M____F____ MAR ITAL STATUS: M S W D # CHILDREN_____

OCCUPATION_________________SS#_______________WORK PHONE______________

E:MAIL ADDRESS:________________________REFERRED BY__________________

PLEASE CHECK THE APPROPRIATE BOX FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD PREVIOUSLY. THIS IS A CONFIDENTIAL REPORT. ***IF YOUR ANSWER IS NEVER, PLEASE LEAVE BLANK.***

O=OCCASIONAL F=FREQUENT C=CONSTANT

O F C **GENERAL**

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

MUSCLE & JOINT

- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Neck pain/stiffness
- ☐ ☐ ☐ Pain between shoulders

Pain/Numbness/Tingling :

- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tail bone
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

O F C **GASTRO-INTESTINAL**

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

EYES, EARS, NOSE & THROAT

- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eye/Lazy eye
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earaches
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noises/ringing
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hearing loss
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus infection/problems
- ☐ ☐ ☐ Sore throats

O F C **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-URINARY

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

FOR WOMEN ONLY

- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramp or backache
- ☐ ☐ ☐ Excessive menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopausal symptoms
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

☐ Yes ☐ No Are you pregnant?

Have you ever had previous chiropractic care?____ If yes, date:_______________________
Do you have Health and Accident Insurance?____ If yes, company____________________
Is this a car accident?☐ Yes ☐ No Is this a Workers Compensation case?☐Yes ☐ No

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD OR PRESENTLY HAVE

☐ AIDS
☐ ALCOHOLISM
☐ APPENDICITIS
☐ AUTOIMMUNE
☐ CANCER__________
☐ ECZEMA
☐ EMPYSEMA
☐ EPILEPSY
☐ GOITER
☐ GOUT
☐ HIV+
☐ MALARIA
☐ MUMPS
☐ PLEURISY
☐ PNEUMONIA
☐ POLIO
☐ RHEUMATIC FEVER
☐ STROKE
☐ TB
☐ VENEREAL DISEASE
☐ WHOOPING COUGH

WHAT IS YOUR MAIN COMPLAINT?____
HOW LONG HAVE YOU HAD THIS CONDITION?_____________PREVIOUS EPISODES?________
IS THIS CONDITION GETTING WORSE? ☐YES ☐NO ☐CONSTANT ☐COMES AND GOES
WHAT AGGRAVATES YOUR CONDITION?____
LIST DIAGNOSIS OR TREATMENT YOU HAVE RECEIVED FOR THIS CONDITION AND OUTCOMES:____
LIST SURGICAL OPERATIONS AND YEARS____
OTHER COMPLAINTS?____

DRUGS YOU NOW TAKE:

☐ ANTI-DEPRESSANTS
☐ TRANQUILIZERS
☐ BIRTH CONTROL PILLS
☐ PAIN MED
☐ MUSCLE RELAXANTS
☐ HORMONES
☐ ANTI-INFLAMMATORIES
☐ AMPHETAMINES(UPPERS)
☐ STEROIDS(TYPE)__________

OTHER:____
DO YOU OR HAVE YOU HAD AN EMOTIONAL DISORDER?
☐ YES ☐ NO WHEN?___________________________TYPE_________________________________
HAVE YOU ANY DRUG ALLERGIES? ☐YES ☐ NO TYPE_________________________________
DATE OF LAST MEDICAL EXAM? ☐ LESS THAN 6 MONTHS ☐ 6-18 MONTHS ☐ OVER 18 MONTH
ARE YOU WEARING: ☐HEEL LIFTS ☐ORTHOTICS ☐ARCH SUPPORTS
HAVE YOU BEEN IN AN AUTO ACCIDENT:
☐PAST YEAR ☐ PAST FIVE YEARS ☐ OVER FIVE YEARS ☐ NEVER
DESCRIBE:____

FAMILY HEALTH INFORMATION(MANY HEALTH PROBLEMS ARE THE RESULT OF HEREDITARY SPINAL WEAKNESSES; THUS INFORMATION ABOUT YOUR FAMILY MEMBERS WILL GIVE US A BETTER UNDERSTANDINGOF 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/BROKEN BONE	☐	☐	______________
BEEN HOSPITALIZED FOR OTHER THAN SURGERY	☐	☐	______________

DATE OF LAST:	LESS THAN 6 MONTHS	6-18 MONTHS	OVER 18 MONTHS	NEVER
SPINAL EXAMINATION	☐	☐	☐	☐
PHYSICAL EXAMINATION	☐	☐	☐	☐
BLOOD TEST	☐	☐	☐	☐

HABITS:

ALCOHOLIC DRINKS(INCLUDING BEER & WINE)____/DAY____/WK____/MONTH____☐RARE ☐NONE
COFFEE:☐REGULAR ☐DECAF ☐BOTH CUPS PER DAY_________
TOBACCO:____/DAY ☐RARE ☐NONE
RECREATIONAL DRUGS:☐DAILY ☐WEEKLY ☐RARE ☐NONE
EXERCISE: ☐DAILY ☐4-6X WK ☐2-3X WK ☐ INCONSISTANT
☐NONE TYPE____
SLEEP: ☐OVER 8 HRS ☐6-8 HRS ☐LESS THAN 6 HOURS ☐TROUBLE FALLING/STAYING ASLEEP
APPETITE:☐HEAVY ☐MODERATE ☐LIGHT ☐EATING DISORDER TYPE:_____________________________
MEALS: ☐ MORE THAN 5X DAY ☐ 4-5X DAY ☐ 3X DAY ☐ 2X DAY ☐ 1X DAY ☐ LESS THAN 1X DAY
ARE YOU A VEGETARIAN? ☐YES ☐NO

EMERGENCY CONTACT/TELEPHONE NUMBER____