APPLICATION FOR CHIROPRACTIC HEALTH SERVICE

CASE NO. _________ DATE _____________________________
NAME ____ BIRTHDATE _______________
WEIGHT __________ WEIGHT __________ OCCUPATION_____________________
REFERRED BY _____________________________________

CONFIDENTIAL CASE HISTORY RECORD

MAJOR COMPLAINTS AND SYMPTONS
____
ARE YOU PREGNANT AT THIS TIME _______ DUE DATE ______
DATE LAST PERIOD BEGAN_______
LOCATION OF GREATEST PAIN ____
WHEN DID YOU FIRST BECOME INJURED OR SICK? _______________________
ANY FAMILY HISTORY OF THIS CONDITION?
____
ANY AUTO ACCIDENTS OR FALLS? ________IF YES, LIST DATE(S) ___________
HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS? _______
MD( ) DO ( ) DC ( )
LENGTH OF TREATMENT ________________________
RESULTS __________________________________
LIST ANY FRACTURES YOU HAVE HAD
____
LIST ANY SURGERIES YOU HAVE HAD
____
DO YOU DESIRE: MAXIMUM IMPROVEMENT ( ) TEMPORARY RELIEF ( )
IS THIS OR WILL THIS BE A WORKERS' COMPENSATION CLAIM? ________
CLAIM # _____________

(SEE REVERSE SIDE – CHECK THE ITEMS THAT PERTAIN TO YOU)

HAVE YOU HAD ANY DIFFICULTY WITH THE FOLLOWING NOW OR IN THE PAST:

(PLACE AN "X" NEXT TO THE ITEMS THAT PERTAIN TO YOU.)

1. HEAD: _______ HEADACHES _______ DIZZINESS _______ SINUS _______
2. EYES: _______ GLASSES _______ PAIN _______ INFLAMMATION _______
3. EARS: _______ HEARING _______ RINGING _______ WAX _______ PAIN _______
4. NOSE: _______ SMELL _______ HAYFEVER _______ HEAD COLDS _______
5. THROAT: _______ SPEECH _______ THYROID _______ TONSILITIS _______
6. NECK: _______ STIFFNESS _______ PAIN _______ TENSION _______
7. SHOULDERS: _______ PAIN _______ STIFFNESS _______ BURSITIS _______
8. ARMS: _____R _____L ELBOWS _____R _____L WRISTS _____R _____L HANDS _____R _____L
9. HEART: _______ PAIN _______ SPASM _______ PALPITATION _______ ATTACK _______
10. HIGH BLOOD PRESSURE: _______ LOW BLOOD PRESSURE: _______
11. LUNGS: _______ TB _______ CHEST PAIN _______ ASTHMA _______
12. ABDOMEN: _______ STOMACH _______ LIVER _______ GALL BLADDER _______
13. INTESTINES: _______ DIGESTION _______ GAS _______ CONSTIPATION _______
14. KIDNEYS: _______ HEMORRHOIDS _______
15. MENSTRUATION: _______ PAIN _______ CRAMPS _______ IRREGULARITY _______
16. DIABETES: _______ CANCER _______
17. NUMBNESS IN ANY BODY PART _______ SWELLING _______
18. DIFFICULTY SLEEPING _______ ANEMIA _______ FAINTING _______
19. PAINFUL JOINTS _______ SWOLLEN JOINTS _______ CRAMPS _______
20. PAIN IN UPPER BACK _______ PAIN IN MIDDLE BACK _______
21. PAIN IN LOWER BACK _______ (HOW LONG?) _______
22. HIPS: _______R _______L THIGH _______R _______L KNEE _______R _______L
23. CALF: _______R _______L ANKLE _______R _______L FOOT _______R _______L
24. ALLERGIES ____
25. ALCOHOL (AMT. PER WEEK) _______ SMOKING (# PER DAY) _______
26. ARE YOU USING ANY DRUGS? (LEGAL OR RECREATIONAL) _______________

NAME ____ DATE ___________________

SIGNATURE ___________________________________