

CLIENT CASE HISTORY

Patient Name _____

Date _____

Please check the appropriate boxes for any symptoms you now have or have had previously. If we do not believe your condition will respond satisfactorily, we will not accept your case. Thank you!

Key: N=Now Present; P=Past Experienced

N P

GENERAL

- Dizziness
- Drop Attacks (fainting)
- Diplopia (double vision)
- Dysarthria (difficulty speaking)
- Dysphagia (difficulty swallowing)
- Ataxia (difficulty walking)
- Nausea
- Numbness
- Allergy
- Chills
- Convulsions
- Fatigue
- Fever
- Headache
- Loss of Sleep
- Loss of Weight
- Nervousness
- Sweats
- Anxiety
- Depression

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot Trouble
- Hernia
- Low Back Pain
- Neck Pain/Stiffness
- Pain Between Shoulders

PAIN OR NUMBNESS IN:

- Shoulders
- Arms
- Hands
- Head (Migraines/Headaches)
- Hips
- Legs
- Knees
- Feet

IMPLANTS

- Pacemaker
- Rods/Pins/Screws
- Joint Replacement _____
- Insulin Pump
- Colon Bag
- Other _____

N P

- Painful Tailbone
- Sciatica
- Spinal Curvature (Scoliosis)
- Swollen Joints

GASTRO-INTESTINAL

- Belching or Gas
- Colon Trouble
- Constipation
- Diarrhea
- Difficult Digestion
- Excessive Hunger
- Gallbladder Trouble
- Hemorrhoids
- Intestinal Worms
- Jaundice
- Liver Trouble
- Pain Over Stomach
- Poor Appetite
- Vomiting
- Vomiting Blood

EYES, EARS, NOSE, THROAT

- Colds
- Crossed Eyes
- Deafness
- Dental Decay/Tooth Pain
- Earache
- Ear Discharge/Pain
- Ringing In Ears
- Enlarged Glands
- Eye Pain
- Failing Vision
- Gum Trouble
- Hay Fever
- Hoarseness
- Nosebleeds
- Sinus Infection
- Sore Throat
- Tonsillitis
- () () Thyroid

N P

CARDIOVASCULAR

- Hardening of the Arteries
- High Blood Pressure
- Low Blood Pressure
- Pain Over Heart
- Poor Circulation
- Rapid Heartbeat
- Slow Heartbeat
- Swelling of Ankles
- TIA's or Stroke

RESPIRATION

- 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)
- Psoriasis Rash (scales)
- Varicose Veins

GENITO-URINARY

- Bedwetting
- Blood in Urine
- Frequent Urination
- Inability to Control Bladder
- Kidney Infection or Stones
- Painful Urination
- Prostate Trouble
- Pus In Urine

FOR WOMEN ONLY

- Breast Lump
- Cramps or Backache
- Excessive Menstrual Flow
- Irregular Cycle
- Menopausal Symptoms
- Vaginal Infections

Are You Pregnant? Yes No

Last Papsmear: _____

List Pregnancies _____births

_____miscarriages

CHECK ANY CONDITIONS YOU HAVE HAD

- | | | | | |
|-------------------------------------|--------------------------------------|---------------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fractures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |

-----TURN OVER PLEASE-----

Past History

Injuries/Surgeries You Have Had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Vehicle Accidents	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Hospitalizations (not Related to surgery)	_____	_____

Medications/Supplements

1. Please list the drugs you are now taking: Nerve Pills Painkillers Muscle Relaxers "Pep" Pills Tranquilizers
 Birth Control Pills Others: _____

2. Please list any nutritional supplements, herbs, or minerals that you are currently taking:

3. Who is your Medical Doctor? _____ OB/GYN? _____
 Dentist? _____

4. What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services; If so, where? _____ Other _____

Family History

1. Are your parents living? If not, why? _____

(Many health problems are hereditary, so the information you give about your family gives us a better idea of your total health picture.)

Side of Family (Mother/Father)	Relation	Past/Present Health Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

1. Do you exercise on a regular basis? Yes No What Type? _____

2. What do you do in your spare time? (hobbies, etc.) _____

3. Do you use: Caffeine = Cups/Day _____ Alcohol = Drinks/Day _____
 Tobacco = How much/Day _____ Recreational Drugs = What & #/Day _____

4. In what position do you sleep? Side Stomach Back Varies

5. Do you sleep well? Yes No

6. Please describe your work:
 Type: Professional Physical Labor Driver Clerical Factory Homemaker Unemployed
 Work Activity: Sitting Standing Light Labor Heavy Labor

7. Please describe your current stress level:
 High Medium Low REASON (if high): _____

Additional General Questions

1. Do you have problems with recurring headaches? Yes No Explain _____

2. Are you losing weight without trying? Yes No

3. Does your pain wake you up at night? Yes No

4. Have you had a sore that doesn't heal? Yes No

5. Have you noticed any unusual bleeding or discharge? Yes No

6. Have you noticed a wart or mole that has changed? Yes No

7. Do you have a persistent, nagging cough? Yes No

8. Is there anything else that has not been covered that you would like the doctor to know? _____