# CONFIDENTIAL PATIENT CASE HISTORY

HEDLUND CHIROPRACTIC P.A.

Get back into life.

*Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.*

**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**. THIS IS A CONFIDENTIAL HEALTH REPORT**.

**O – OCCASIONAL F- FREQUENT C - CONSTANT**

| O | F | C | |
|---|---|---|---|
| | | | **GENERAL** |
| ☐ | ☐ | ☐ | Allergy |
| ☐ | ☐ | ☐ | Chills |
| ☐ | ☐ | ☐ | Convulsions |
| ☐ | ☐ | ☐ | Dizziness |
| ☐ | ☐ | ☐ | Fainting |
| ☐ | ☐ | ☐ | Fatigue |
| ☐ | ☐ | ☐ | Fever |
| ☐ | ☐ | ☐ | Headache / Migraine |
| ☐ | ☐ | ☐ | Loss of sleep |
| ☐ | ☐ | ☐ | Loss of weight |
| ☐ | ☐ | ☐ | Anxiety |
| ☐ | ☐ | ☐ | Depression |
| ☐ | ☐ | ☐ | Neuralgia (nerve pain) |
| ☐ | ☐ | ☐ | Numbness |
| ☐ | ☐ | ☐ | Sweats |
| ☐ | ☐ | ☐ | Tremors |
| | | | **MUSCLE & JOINT** |
| ☐ | ☐ | ☐ | Arthritis |
| ☐ | ☐ | ☐ | Bursitis |
| ☐ | ☐ | ☐ | Fibromyalgia |
| ☐ | ☐ | ☐ | Foot trouble |
| ☐ | ☐ | ☐ | Hernia |
| ☐ | ☐ | ☐ | Low back pain (Lumbago) |
| ☐ | ☐ | ☐ | Neck pain or stiffness |
| ☐ | ☐ | ☐ | Osteopenia |
| ☐ | ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | ☐ | Pain between shoulders |
| | | | Pain or numbness in: |
| ☐ | ☐ | ☐ | Shoulders |
| ☐ | ☐ | ☐ | Arms |
| ☐ | ☐ | ☐ | Elbows |
| ☐ | ☐ | ☐ | Hands |
| ☐ | ☐ | ☐ | Hips |
| ☐ | ☐ | ☐ | Legs |
| ☐ | ☐ | ☐ | Knees |
| ☐ | ☐ | ☐ | Feet |
| ☐ | ☐ | ☐ | Painful tail bone |
| ☐ | ☐ | ☐ | Poor posture |
| ☐ | ☐ | ☐ | Sciatica |
| ☐ | ☐ | ☐ | Scoliosis |
| ☐ | ☐ | ☐ | Spinal Curvature |
| ☐ | ☐ | ☐ | Swollen joints |

| O | F | C | |
|---|---|---|---|
| | | | **GASTRO-INTESTINAL** |
| ☐ | ☐ | ☐ | Acid Reflux / GERD |
| ☐ | ☐ | ☐ | Belching or gas |
| ☐ | ☐ | ☐ | Colitis |
| ☐ | ☐ | ☐ | Colon trouble |
| ☐ | ☐ | ☐ | Constipation |
| ☐ | ☐ | ☐ | Diarrhea |
| ☐ | ☐ | ☐ | Difficult digestion |
| ☐ | ☐ | ☐ | Abdominal bloating |
| ☐ | ☐ | ☐ | 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 / Frequently sick |
| ☐ | ☐ | ☐ | Crossed eyes |
| ☐ | ☐ | ☐ | Deafness |
| ☐ | ☐ | ☐ | Dental decay/Gum trouble |
| ☐ | ☐ | ☐ | Earache |
| ☐ | ☐ | ☐ | Ear discharge |
| ☐ | ☐ | ☐ | Ear noises |
| ☐ | ☐ | ☐ | Enlarged glands |
| ☐ | ☐ | ☐ | Enlarged thyroid |
| ☐ | ☐ | ☐ | Eye pain |
| ☐ | ☐ | ☐ | Failing vision |
| ☐ | ☐ | ☐ | Far sightedness |
| ☐ | ☐ | ☐ | Hay fever |
| ☐ | ☐ | ☐ | Hoarseness |
| ☐ | ☐ | ☐ | Nasal obstruction |
| ☐ | ☐ | ☐ | Near sightedness |
| ☐ | ☐ | ☐ | Nose bleeds |
| ☐ | ☐ | ☐ | Sinus infection |
| ☐ | ☐ | ☐ | Sore throat |
| ☐ | ☐ | ☐ | Tonsillitis |

| O | F | C | |
|---|---|---|---|
| | | | **CARDIO-VASCULAR** |
| ☐ | ☐ | ☐ | Hardening of arteries |
| ☐ | ☐ | ☐ | High blood pressure |
| ☐ | ☐ | ☐ | Low blood pressure |
| ☐ | ☐ | ☐ | Pain over heart |
| ☐ | ☐ | ☐ | Poor circulation |
| ☐ | ☐ | ☐ | Rapid heartbeat |
| ☐ | ☐ | ☐ | Slow heartbeat |
| ☐ | ☐ | ☐ | 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 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?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

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

**PLEASE PRINT**

List surgical operation and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers
☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others: _____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

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? | ☐ | ☐ | _____ |

| **DO YOU:** | | | |
|---|---|---|---|
| Now take vitamins or minerals? | ☐ | ☐ | _____ |
| Think you may need vitamins or minerals? | ☐ | ☐ | _____ |
| Have an allergy to any drug? | ☐ | ☐ | _____ |

**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 | ☐ | ☐ | ☐ | ☐ |
| Dental X-ray | ☐ | ☐ | ☐ | ☐ |
| Urine test | ☐ | ☐ | ☐ | ☐ |

**HABITS**

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

**IN CASE OF EMERGENCY:** (Name of relative or close friend not living in your home):

**NAME:** _____PHONE:_____

**ADDRESS**: _____