CONFEDERATION CHIROPRACTIC CLINIC

CHIROPRACTIC CONFIDENTIAL CASE HISTORY

Name:_____ Date:_____

Address: _____

City/Town:_____ Postal Code:_____

Home #: _____Cell#:_____ Work/Other:_____Ext:_____

Hospitalization #:_____ DOB:_____

Spouse Name:_____ Number of Children:_____

Names & Ages of Children:_____

Employer:_____ Position: _____

If you are employed, please describe what activities you do on a daily basis (ex: lifting, typing, prolonged standing, etc.)

_____

Please check if any of these relate to you: _____WCB _____SGI _____ SS/FIP _____DVA

Email:_____

Would you like an email appointment reminder? Yes____ No____

How did you hear about our clinic?_____

Emergency Contact

Name:_____ Relationship:_____

Number:_____

Health Information

Height:_____ Weight:_____ Shoe Size:_____

Foot Width: ( ) Regular ( ) Narrow ( ) Wide Activity Level: ( ) Low ( ) Medium ( ) High

Do you currently wear orthotics? _____ Primary Insurance Provider: _____

Do you have Diabetes or Arthritis? _____ Do you have foot pain? _____

Have you been diagnosed with a foot condition? (if yes please explain) _____

Have you had a foot or ankle surgery? (if yes please explain) _____

Dear Patient: Please complete the 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.

Health Information:

Briefly describe your current condition and reason for consulting the clinic:

_____

_____

Does this concern interfere with ( ) Work ( ) Sleep ( ) Daily Activity ( ) None

Describe the impact this issue has on your daily activity:

_____

_____

Describe your goals for care:

_____

_____

Have you seen any other health care providers for this current problem? _____

Have you had previous chiropractic care? Yes_____ No_____When?_____

By whom?_____ For what condition?_____

List surgical procedures & years:_____

Medications you take currently: ( ) Pain Killers ( ) Insulin ( ) Birth Control ( ) Muscle Relaxants

List others including vitamins and supplements:_____

Have you been in an auto accident? Yes _____No____Date(s):_____

Briefly describe the accident(s):_____

Have you had x-rays of your spine? Yes_____No____ When?_____Where?_____

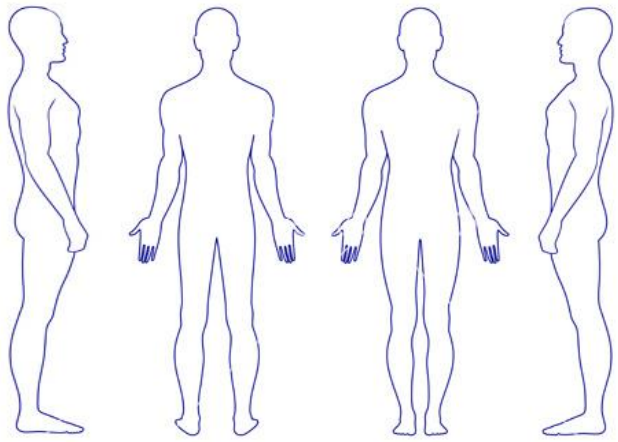
Do you sleep well? Yes_____No____ In what position do you sleep?_____

Do you participate in a regular exercise program?_____

Do you have any diagnosed medical conditions?_____

Date of your last physical examination:_____ Family Physician:_____

MARK AREAS OF CONCERN BELOW



Family Health History

Many health problems are a result of hereditary spinal weakness and have a tendency to occur in families. Please fill in the following chart

	Age	Health Problem
Father		
Mother		
Brothers		
Sisters		
Children		

Below is a list of diseases which may seem quite unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING AND DATE

_____Pneumonia	_____Mumps	_____Influenza
_____Rheumatic Fever	_____Small Pox	_____Pleurisy
_____Polio	_____Chicken Pox	_____Arthritis
_____Tuberculosis	_____Diabetes	_____Epilepsy
_____Whooping Cough	_____Cancer	_____Mental Disorder
_____Anemia	_____Heart Disease	_____Lumbago
_____Measles	_____Thyroid	_____Eczema

Please Check (☑) any of the following conditions you are currently experiencing.
Please Circle (○) any of the following conditions you have had in the last year.

General Symptoms

_____Fevers	_____Loss of Sleep	_____Loss of Weight
_____Sweats	_____Nervousness	_____Fainting

Respiratory Symptoms

_____Spitting Up Blood	_____Shortness of Breath	_____Chronic Cough
_____Spitting Up Phlegm	_____Difficulty Breathing	_____ Chest Pain

Cardiovascular Systems

_____ Rapid Beating Heart _____ High Blood Pressure _____Swollen Ankles

_____Slow Beating Heart _____ Low Blood Pressure _____Pain Over Heart

_____Hardening of Arteries _____Poor Circulation

Neurological Symptoms

_____Visual Disturbance _____Convulsions _____Coordination

_____Dizziness _____ Mood Changes _____Headaches

Muscle and Joint

_____ Stiff Neck _____ Swollen Joints _____Foot Trouble

_____ Backache _____Neck Pain _____ Arthritis

_____Spinal Curvature _____Pain In Shoulders

E.E.N.T

_____Eye Pain _____Hoarseness _____Sinus Infection

_____Deafness _____Nosebleeds _____Nasal Drainage

_____Asthma _____Enlarged Glands

Genitourinary

_____Frequent Urination _____Kidney Infection _____Blood In Urine

_____Painful Urination _____Prostate Trouble _____Urine Control

Gastrointestinal

_____Poor Appetite _____ Constipation _____Colitis

_____Difficult Digestion _____Gallbladder/Jaundice _____Nausea

_____Vomiting Blood

For Women Only *Are You Pregnant?* _____

Date of Last Cycle_____

_____Vaginal Discharge _____Lumps/Pain in Breasts _____Irregular Cycle

_____Cramps or Backache _____Menopausal Symptoms _____Hot Flashes