

# CONFIDENTIAL PATIENT CASE HISTORY

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.

Whom may we thank for referring you to our office?

ABOUT YOU	
Today's Date :	File #
Name:	
Home Address:	
Home Phone #	Work #
Social Security #	Birthdate
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Occupation:	
Employer's Address:	
Spouse's Name:	#Children

DO YOU...	
Smoke	<input type="checkbox"/> No <input type="checkbox"/> Yes 1-2-3-4 packs/day
Drink Coffee	<input type="checkbox"/> No <input type="checkbox"/> Yes 1-2-3-4 cups
Drink Tea	<input type="checkbox"/> No <input type="checkbox"/> Yes 1-2-3-4 cups
Drink Diet soda	<input type="checkbox"/> No <input type="checkbox"/> Yes 1-2-3-4
Exercise regularly	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eat a balanced diet	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sleep 8 hours a day	<input type="checkbox"/> No <input type="checkbox"/> Yes

REASON FOR VISIT	
Have you ever been to a Chiropractor before?	D.C.'s Name
Who is your Midwife or Ob/Gyn	Phone #
The reason for this visit is a result of <input type="checkbox"/> Breech presentation <input type="checkbox"/> backache of pregnancy <input type="checkbox"/> headache <input type="checkbox"/> trauma <input type="checkbox"/> chronic condition <input type="checkbox"/> other	
How many pregnancies have you had?	Vaginal Delivery _____ Cesarean Section _____
Please explain any complications with this or past pregnancies _____	
Are you taking any medications and/or vitamins?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain _____

