CONFIDENTIAL PATIENT CASE HISTORY HOGAN CHIROPRACTIC SERVICES

Dear Patient: Please complete *both sides* of this questionnaire. Your answers will help us determine if chiropractic can help you.

NAME: ________________________________ **HOME PHONE:** __________ **CELL:** _________ **E-MAIL** ______________
ADDRESS: __________________________________ **CITY:** ____________________________**STATE:** _____**ZIP:** _______
DATE OF BIRTH: _____________ **AGE:** _______ **M** ___ **F** ___ **MARITAL STATUS:** _____ **NO. OF CHILDREN:** _________
OCCUPATION: ____ **SOCIAL SECURITY NUMBER:** _____________________
WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____________________________ **REFERRED BY:** __________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

OCCASIONAL = O **(Check one)**
FREQUENT = F
CONSTANT = C

THIS IS A CONFIDENTIAL HEALTH REPORT.

O F C GENERAL
☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss Of Sleep
☐ ☐ ☐ Loss Of Weight
☐ ☐ ☐ Nervousness/Depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLES & JOINTS
☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot Trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low Back Pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck Pain or Stiffness
☐ ☐ ☐ Temporomandibular Joint
☐ ☐ ☐ Pain Between Shoulders

Pain Or Numbness In:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful Tail Bone
☐ ☐ ☐ Poor Posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen Joints

O F C GASTRO-INTESTINAL
☐ ☐ ☐ Belching Or Gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon Trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult Digestion
☐ ☐ ☐ Distension Of Abdomen
☐ ☐ ☐ Excessive Hunger
☐ ☐ ☐ Gall Bladder Trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal Worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver Trouble
☐ ☐ ☐ Nauasea
☐ ☐ ☐ Pain Over Stomach
☐ ☐ ☐ Poor Appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting Of Blood

EYES, EARS, NOSE, & THROAT
☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed Eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear Discharge
☐ ☐ ☐ Ear Noise
☐ ☐ ☐ Enlarged Glands
☐ ☐ ☐ Enlarged Thyroid
☐ ☐ ☐ Eye Pain
☐ ☐ ☐ Failing Vision
☐ ☐ ☐ Far-Sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus Infection
☐ ☐ ☐ Sore Throat
☐ ☐ ☐ Tonsillitis

O F C CARDIO-VASCULAR
☐ ☐ ☐ Hardening Of The Arteries
☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Low Blood Pressure
☐ ☐ ☐ Pain Over Heart
☐ ☐ ☐ Poor Circulation
☐ ☐ ☐ Rapid Heart Beat
☐ ☐ ☐ Slow Heart Beat
☐ ☐ ☐ 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

FOR WOMEN ONLY
☐ ☐ ☐ Congested Breasts
☐ ☐ ☐ Cramps Or Backache
☐ ☐ ☐ Excessive Menstrual Flow
☐ ☐ ☐ Hot Flashes
☐ ☐ ☐ Irregular Cycle
☐ ☐ ☐ Lumps In Breast
☐ ☐ ☐ Menopausal Symptoms
☐ ☐ ☐ Painful Menstruation
☐ ☐ ☐ Vaginal Discharge
☐ Yes ☐ No: Are You Pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Cancer
☐ Chorea
☐ Cold Sores
☐ Diabetes
☐ Diptheria
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple Sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐Venereal Disease
☐ Whooping Cough

Have you ever had previous Chiropractic care? __________________ **If yes, date of last care:** ___________________________
Do you have Health and Accident Insurance? ___________________ **If yes, with what company?** ________________________
Is this an Industrial Accident Case? YES _____ **NO** ____

Please turn over to continue on to side two.

Confidential Patient Case History   Hogan Chiropractic Services

What is your major complaint? ____

____

Other Complaints? ____
How Long Have You Had This Condition? ___________ Have You Had This Or Similar Conditions In The Past? __________________
What Activities Aggravate Your Condition? ____

Is This Condition Getting Progressively Worse? ☐ Yes ☐ No ☐ Constant ☐ Comes And Goes
Is This Condition Interfering With Your : ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other ______________________________

How Long Has It Been Since You Really Felt Good? ____
What Do You Believe Is Wrong With You? ____
List Surgical Operations And Years: ____

____

Drugs You Now Take: ☐Nerve Pills ☐Pain Killers ☐Muscle Relaxers ☐"Pep" Pills ☐Tranquilizers ☐Insulin ☐Birth Control Pills ☐Other _______
Dental Visits: ☐ Every Six Months ☐ Yearly ☐ Toothache or "Emergency" Only ☐ Complete Dentures
Age Of Mattress: ______________________ ☐ Comfortable ☐ Uncomfortable — Do You Have A Bed Board? ______________________
Are You Wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports
Have You Been In An Automobile Accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never
Describe: ____
Have You Had Any Other Personal Injury Or Accident? (Broken Bones, Sit Down Falls, Head Injuries -Think back to your childhood)
☐ Past Year ☐ Past 5 Years ☐ Over 5 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? ______________________________

FAMILY HEALTH INFORMATION. (Many Health Problems Are The Result Of Heredetary Spinal Weaknesses; Thus Information About Your Family Members Will Give Us A Better Understanding Of Your Total Health Picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:		DESCRIBE BRIEFLY
Been Knocked Unconscious?	☐ Yes ☐ No	______________________
Used A Cane, Crutch, Or Other Support?	☐ Yes ☐ No	______________________
Been Treated For A Spine Or Nervous Disorder?	☐ Yes ☐ No	______________________
Had A Fractured Bone?	☐ Yes ☐ No	______________________
Been Hospitalized For Other Than Surgery?	☐ Yes ☐ No	______________________
DO YOU:		
Now Take Vitamins Or Minerals?	☐ Yes ☐ No	______________________
Think You May Need Vitamins Or Minerals?	☐ Yes ☐ No	______________________
Have An Allergy To Any Drug?	☐ Yes ☐ No	______________________

DATE OF LAST:

Spinal Examination	Less Than 6 Mo. ☐	6-18 Mo. ☐	Over 18 Mo. ☐	Never ☐
Physical Examination	Less Than 6 Mo. ☐	6-18 Mo. ☐	Over 18 Mo. ☐	Never ☐
Blood Test	Less Than 6 Mo. ☐	6-18 Mo. ☐	Over 18 Mo. ☐	Never ☐
Chest X-Ray	Less Than 6 Mo. ☐	6-18 Mo. ☐	Over 18 Mo. ☐	Never ☐
Spinal X-Ray	Less Than 6 Mo. ☐	6-18 Mo. ☐	Over 18 Mo. ☐	Never ☐
Dental X-Ray	Less Than 6 Mo. ☐	6-18 Mo. ☐	Over 18 Mo. ☐	Never ☐
Urine Test	Less Than 6 Mo. ☐	6-18 Mo. ☐	Over 18 Mo. ☐	Never ☐

HABITS

Alcohol	☐ Heavy ☐ Moderate ☐ Light ☐ None	Coffee	☐ Heavy ☐ Moderate ☐ Light ☐ None
Tobacco	☐ Heavy ☐ Moderate ☐ Light ☐ None	Other caffeine sources: ______________	
Exercise	☐ Heavy ☐ Moderate ☐ Light ☐ None	Drugs	☐ Heavy ☐ Moderate ☐ Light ☐ None
Appetite	☐ Heavy ☐ Moderate ☐ Light ☐ None	Sleep	☐ Heavy ☐ Moderate ☐ Light ☐ None

In Case Of Emergency: (Name of relative or close friend not living in your home) Name: ______________________________
Address: ______________________________
Phone Number: ______________________________