

Client Case History (Confidential)

Please fill out this questionnaire. Your answers will determine what care will be most appropriate can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case. Thank you!

NAME _____ DATE _____ AGE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE _____ WORK PHONE _____ DATE OF BIRTH _____
 SEX M/F _____ MARITAL STATUS S/M/D/W _____ #CHILDREN _____ SPOUSE _____
 WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____
 S.S. # _____ NAME OF EMERGENCY CONTACT _____
 (RELATIVE/FRIEND) PHONE # _____ E-Mail Address _____ @ _____

Please check the appropriate boxes for any symptoms you now have or have had previously. We need all the facts about your health before we can accept your case.

<p>N – Now present P – Past experienced N P GENERAL <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> Drop attacks (fainting) <input type="checkbox"/> <input type="checkbox"/> Diplopia (visual disturbances) <input type="checkbox"/> <input type="checkbox"/> Dysarthria (difficulty speaking) <input type="checkbox"/> <input type="checkbox"/> Dysphagia (difficulty swallowing) <input type="checkbox"/> <input type="checkbox"/> Ataxia (difficulty walking) <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergy <input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> Convulsions <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> Loss of sleep <input type="checkbox"/> <input type="checkbox"/> Loss of weight <input type="checkbox"/> <input type="checkbox"/> Nervousness <input type="checkbox"/> <input type="checkbox"/> Sweats <input type="checkbox"/> <input type="checkbox"/> Anxiety <input type="checkbox"/> <input type="checkbox"/> Depression</p> <p>MUSCLE & JOINT <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Bursitis <input type="checkbox"/> <input type="checkbox"/> Foot trouble <input type="checkbox"/> <input type="checkbox"/> Hernia <input type="checkbox"/> <input type="checkbox"/> Low back pain <input type="checkbox"/> <input type="checkbox"/> Neck pain/stiffness <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p>PAIN OR NUMBNESS IN: <input type="checkbox"/> <input type="checkbox"/> Shoulders <input type="checkbox"/> <input type="checkbox"/> Arms <input type="checkbox"/> <input type="checkbox"/> Elbows <input type="checkbox"/> <input type="checkbox"/> Hands <input type="checkbox"/> <input type="checkbox"/> Hips <input type="checkbox"/> <input type="checkbox"/> Legs <input type="checkbox"/> <input type="checkbox"/> Knees <input type="checkbox"/> <input type="checkbox"/> Feet</p>	<p>N P <input type="checkbox"/> <input type="checkbox"/> Painful tail bone <input type="checkbox"/> <input type="checkbox"/> Sciatica <input type="checkbox"/> <input type="checkbox"/> Spinal curvature <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p>GASTRO-INTESTINAL <input type="checkbox"/> <input type="checkbox"/> Belching or gas <input type="checkbox"/> <input type="checkbox"/> Colon trouble <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Difficult digestion <input type="checkbox"/> <input type="checkbox"/> Distention of abdomen <input type="checkbox"/> <input type="checkbox"/> Excessive hunger <input type="checkbox"/> <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> <input type="checkbox"/> Intestinal worms <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> Liver trouble <input type="checkbox"/> <input type="checkbox"/> Pain over stomach <input type="checkbox"/> <input type="checkbox"/> Poor appetite <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> Vomiting blood</p> <p>EYES, EARS, NOSE, THROAT <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Colds <input type="checkbox"/> <input type="checkbox"/> Crossed eyes <input type="checkbox"/> <input type="checkbox"/> Deafness <input type="checkbox"/> <input type="checkbox"/> Dental decay <input type="checkbox"/> <input type="checkbox"/> Earache <input type="checkbox"/> <input type="checkbox"/> Ear discharge <input type="checkbox"/> <input type="checkbox"/> Ear noises/Tinnitus <input type="checkbox"/> <input type="checkbox"/> Enlarged glands <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> <input type="checkbox"/> Eye pain <input type="checkbox"/> <input type="checkbox"/> Failing vision <input type="checkbox"/> <input type="checkbox"/> Gum trouble <input type="checkbox"/> <input type="checkbox"/> Hay fever <input type="checkbox"/> <input type="checkbox"/> Hoarseness <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> <input type="checkbox"/> Nosebleeds <input type="checkbox"/> <input type="checkbox"/> Sinus infection <input type="checkbox"/> <input type="checkbox"/> Sore throat <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p>	<p>N P CARDIO-VASCULAR <input type="checkbox"/> <input type="checkbox"/> Hardening of the arteries <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Low blood pressure <input type="checkbox"/> <input type="checkbox"/> Pain over heart <input type="checkbox"/> <input type="checkbox"/> Poor circulation <input type="checkbox"/> <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> <input type="checkbox"/> Slow heart beat <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p>RESPIRATION <input type="checkbox"/> <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> Chronic cough <input type="checkbox"/> <input type="checkbox"/> Difficult breathing <input type="checkbox"/> <input type="checkbox"/> Spitting up blood <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p>SKIN <input type="checkbox"/> <input type="checkbox"/> Boils <input type="checkbox"/> <input type="checkbox"/> Bruise easily <input type="checkbox"/> <input type="checkbox"/> Dryness <input type="checkbox"/> <input type="checkbox"/> Hives or allergy <input type="checkbox"/> <input type="checkbox"/> Itching <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash) <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p>GENITO-URINARY <input type="checkbox"/> <input type="checkbox"/> Bed wetting <input type="checkbox"/> <input type="checkbox"/> Blood in urine <input type="checkbox"/> <input type="checkbox"/> Frequent urination <input type="checkbox"/> <input type="checkbox"/> Inability to control bladder <input type="checkbox"/> <input type="checkbox"/> Kidney infection or stones <input type="checkbox"/> <input type="checkbox"/> Painful urination <input type="checkbox"/> <input type="checkbox"/> Prostate trouble <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p> <p>FOR WOMEN ONLY <input type="checkbox"/> <input type="checkbox"/> Congested breasts <input type="checkbox"/> <input type="checkbox"/> Cramps or backache <input type="checkbox"/> <input type="checkbox"/> Excessive menstrual flow <input type="checkbox"/> <input type="checkbox"/> Hot flashes <input type="checkbox"/> <input type="checkbox"/> Irregular cycle <input type="checkbox"/> <input type="checkbox"/> Menopausal symptoms <input type="checkbox"/> <input type="checkbox"/> Painful menstruation <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? List pregnancies _____ births _____ miscarriages</p>
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CHECK ANY CONDITIONS YOU HAVE HAD

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis | |

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 this condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other _____

List previous diagnoses and treatments you have received for this condition _____

What do you believe is wrong with you? _____

List all surgical operations you have had and when they occurred _____

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

Others: _____

Have you ever had oral surgery? Yes No Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

Describe: _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary weaknesses, thus information about your family members will give us a better idea of your total health picture.)

SIDE OF FAMILY (MOTHER/FATHER	RELATION	PAST/PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU:	YES	NO	DESCRIBE BRIEFLY
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Now take any medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you ever had chiropractic care? **Y / N** Name of the practice? _____ Date _____

DATE OF LAST:	Less than 6 months	6-18 Months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise/Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED FOR IN THE PAST 10 YEARS
(NOT ALREADY DISCUSSED):

I understand that my care may involve the making of judgments that are based upon information obtained through the IQS interview process. Therefore, the above information is true to the best of my knowledge. I also understand that the practice of any healing art is not an exact science and that no guarantee of results will be made.

CLIENT'S SIGNATURE: _____ DATE: _____