LONE TREE
CHIROPRACTIC
& NATURAL HEALTH CENTER

CONFIDENTIAL CASE HISTORY

Please complete this questionnaire. Your answers will help us determine how our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. _____

Address: _____ City: _____

State/Zip code: _____ Date of Birth: m____ d ____ yr ____ Marital Status: □ Married □ Single

Home Telephone: _____ Business Telephone: _____

Cellular Telephone: _____ e-mail address: _____

Employer: _____ Address: _____

Occupation: _____ Hobbies: _____

Spouse's Name: _____ Children's Names: _____

Children's Names: _____ Children's Names: _____

How did you hear about our office? _____

HEALTH INFORMATION

Have you ever been to a chiropractor before? □ Yes □ No

If so, what was the reason? _____

Have you had previous healthcare for this problem? □ Yes □ No

If yes, where? _____ When? _____

Have you ever had physical therapy before? □ Yes □ No Are you interested in having physical therapy? □ Yes □ No

Have you ever had massage therapy before? □ Yes □ No Are you interested in having massage therapy? □ Yes □ No

REASON FOR CONSULTING OUR OFFICE

□ I have a specific problem and require help only with this problem.

□ After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.

□ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.

□ I have no symptoms and feel well. I am interested in strategies to help me to continue to feel well, or even better.

What is/are your major complaint(s)? _____

How long have you had this condition?_____

Have you had this or similar conditions in the past? □ Yes □ No If yes, when? _____

What activities aggravate your condition? _____

What makes it better?_____

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 well? _____

List surgical operations and/or major injuries: _____

List any prescription drugs, over the counter drugs, vitamins and natural supplements you currently take: _____

_____

Are you wearing □ Heel Lifts □ Sole Lifts □ Inner soles □ Arch support □ Orthotics

Have you been in an auto accident: □ Never □ Recently □ Past year □ Past 5 years or more

Describe the accident: _____

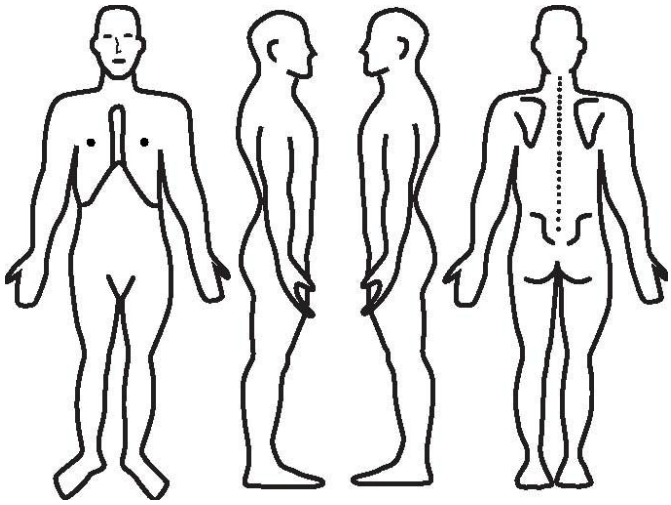
Have you had any other personal injury or accident: □ Never □ Recently □ Past year □ Past 5 years or more

Describe: _____

Date of most recent physical examination: _____

PLEASE MARK THE AREAS OF PAIN AND/OR DISCOMFORT ON THE FIGURES BELOW:

Mark an **X** on the picture where you continue to have pain, numbness, or tingling.



Front Right Left Back

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

□ Sharp	□ Dull	□ Throbbing
□ Numbness	□ Aching	□ Shooting
□ Burning	□ Tingling	□ Cramps
□ Stiffness	□ Swelling	□ Other

How often do you have this pain?_____

_____

Are you affected by any of the following? Please check: O = Occasionally F = Frequently C = Constantly

	O F C		O F C		O F C
Asthma	□ □ □	Headaches	□ □ □	Heartburn	□ □ □
Backache	□ □ □	Sinus trouble	□ □ □	Migraines	□ □ □
Neck pain	□ □ □	Digestive upset	□ □ □	***Females Only:***	
Earache	□ □ □	Dizziness	□ □ □	Painful menstruation	□ □ □
Sore throat	□ □ □	Shoulder pain	□ □ □	PMS	□ □ □
Foot pain	□ □ □	Leg pain	□ □ □	Are you pregnant?	*Yes* □ *No* □

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgement for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ Dated: _____