

NOEL CHIROPRACTIC PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.
THANK YOU.

Name _____ Birthday _____ Sex M F

Address _____ City _____ Zip _____

Soc Sec # _____ Home Phone _____ Work _____ Cell _____

Marital Status: M S D W Children, Ages _____ Spouse's Name _____

Your Occupation _____ Your Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse?(Please Describe) _____

Do any positions make it feel better?(Please Describe) _____

Is this condition: Improved Unchanged Getting Worse

Other doctors or therapists whom have treated THIS condition:

What do you think caused this condition? _____

List surgical operations and years: _____

Do you have a family physician? (Please include doctor's name and office) _____

May we have authorization to contact your family physician? _____

Medications, dosage and frequency: _____

Have you been in an auto accident or had any other personal injury? Y N
Describe _____

Signature _____ Date _____

Parent/Guardian _____ Date _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

<u>GENERAL</u>	<u>NOW</u>	<u>PAST</u>	<u>THROAT</u>	<u>NOW</u>	<u>PAST</u>	<u>GASTROINTESTINAL</u>	<u>NOW</u>	<u>PAST</u>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
						Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
<u>SKIN</u>			<u>NECK</u>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>				Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<u>BREASTS</u>			Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
			Discharge	<input type="checkbox"/>	<input type="checkbox"/>			
<u>HEAD</u>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>				Stones	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<u>LUNGS</u>			Burning	<input type="checkbox"/>	<input type="checkbox"/>
			Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
<u>EARS</u>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Urine Color	_____	
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between Periods	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>				Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEART</u>			Itching	<input type="checkbox"/>	<input type="checkbox"/>
			Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
<u>NOSE</u>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type _____		
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Age at First Period _____		
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Cycle _____ Days		
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow _____ Days		
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies _____		
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births _____		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>				No. of Abortions _____		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<u>BLOOD</u>			Menstrual Flow <input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light		
			Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Last Period _____		
<u>MOUTH</u>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Last Pap Smear _____		
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Last Vaginal Exam _____		
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Last Mammogram _____		
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Last Prostate Exam _____		
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>			
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				<u>NAME</u> _____		
Blisters	<input type="checkbox"/>	<input type="checkbox"/>						

NEUROLOGIC **NOW** **PAST**

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- In-co-ordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

ENDOCRINE

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Hair Changes
- Breast Changes

IMMUNIZATION/VACCINATION

- DPT
- Mumps
- Smallpox
- Typhoid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

BLOOD TYPE

- A+ A-
- B+ B-
- AB+ AB-
- O+ O-
- Other

BLOOD TRANSFUSIONS

- Date _____
- Date _____
- Date _____
- Date _____

PSYCHIATRIC **NOW** **PAST**

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

PAST MEDICAL HISTORY. Check only the one you have had in the past.

- Hay Fever
- Mumps
- Rheumatic Fever
- Allergies
- Angina
- Cancer
- Tumor
- Blood Disease
- Leukemia
- Heart Trouble
- Varicose Veins
- Phlebitis
- Hypertension
- Stroke
- Ulcers
- Jaundice
- Skin Trouble
- Gallstones
- Liver Trouble
- Hepatitis
- Parasites
- Osteoporosis

MUSCULOSKELETAL **NOW** **PAST**

- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain

- Epilepsy
- Paralysis
- Polio
- Mental Illness
- Alcoholism
- Depression
- Nervous Breakdown
- Migraine
- Gout
- Hemorrhoids
- Prostate Problems
- Sexual Problems
- Gonorrhea
- Syphilis
- Diabetes
- Bladder Trouble
- Kidney Stones
- Kidney Infections
- Diabetes
- Bladder Trouble
- Dysentery

Date of Last Chest X Ray _____ Normal Abnormal
 Last TB Skin Test _____ Normal Abnormal
 Allergies: _____

Patient Name _____ **Date** _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? Y N If Yes, how many pounds? _____

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per week _____

Smoking Current Previous Packs/Day # of Years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ # of Years _____

Caffeine Cups/Day _____ # of Years _____

Aspirin # / Day _____ # of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ΔΔΔΔ Numbness ==== Pins/Needles ○○○○ Burning XXXX Stabbing ////

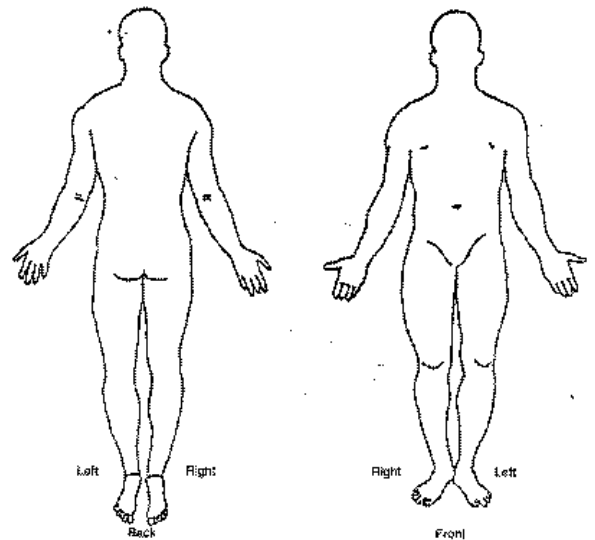
MARK AN "X" ON THE LINES:

How bad are your symptoms now?

[_____]
None Most Severe

How bad have they been in the past?

[_____]
None Most Severe



Please Print Patient Name _____ Date _____