CONFIDENTIAL PATIENT CASE HISTORY

Bruce Chiropractic
+comprehensive care

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

Name:_____ Birthdate:_____ Sex: ❑ Male ❑ Female

Address:_____City: _____State:_____ Zip: _____

Social Security#:_____ Home Phone:_____ Work:_____

Cell:_____ Email: _____

Marital Status: ❑ M ❑ S ❑ D ❑ W Children, Ages: _____

Spouse's Name _____

Occupation:_____ Employer: _____

What is your primary complaint? _____

Do you have a secondary complaint? _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

Do any positions make it feel worse? (i.e. bending, lifting, standing, sleeping, sitting) _____

_____

Does anything make it feel better? (i.e. ice, heat, rest, medication, change in postion) _____

_____

Does the pain radiate? ❑ Yes ❑ No If yes, where? _____

Do you experience numbness or tingling? ❑ Yes ❑ No If yes, where? _____

Does it change throughout the day? _____

Does it interrrupt your sleep? ❑ Yes ❑ No If yes, how often during the night? _____

Is this condition: ❑ Improved ❑ Unchanged ❑ Getting Worse

Is this condition interferring with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other_____

Other doctors or therapists who have treated THIS condition: _____

What do you think caused this condition? _____

Please list any surgeries and their approximate dates: _____

Do you have a family practitioner? (Doctor/Practice): _____

Medications: _____

_____

For what?_____

Supplements/Vitamins: _____

Have you been in a prior auto accident or had any personal injury other than what you are seeing us for today?

❑ Yes ❑ No

Details of injury:_____

_____

Signature:_____ Date:_____

Parent/Guardian:_____ Date: _____

MEDICAL HISTORY

Please only select all that apply to YOU, whether past or present.

- Angina ❑
- Cancer ❑
- Tumor ❑
- Blood Disease ❑
- Leukemia ❑
- Heart Trouble ❑
- Varicose Veins ❑
- Phlebitis ❑
- Hypertension ❑
- Stroke ❑
- Ulcers ❑
- Jaundice ❑
- Skin Troubles ❑
- Gallstones ❑
- Liver Trouble ❑
- Hepatitis ❑
- Epilepsy ❑
- Paralysis ❑
- Polio ❑
- Mental Illness ❑
- Alcoholism ❑
- Depression ❑
- Nervous Breakdown ❑
- Migraine/Headaches ❑
- Gout ❑
- Hemorrhoids ❑
- Prostate Problems ❑
- Sexual Problems ❑
- Gonorrhea ❑
- Syphilis ❑
- Diabetes ❑
- Bladder Trouble ❑
- Kidney Stones ❑
- Kidney Infections ❑
- Bladder Trouble ❑
- IBS ❑
- Osteoperosis/Osteopenia ❑
- Insomnia/Trouble Sleeping ❑

IMMUNIZATIONS/ VACCINES

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

DO YOU HAVE A PACEMAKER? ❑ Yes ❑ No

Date of Last X-Ray of Area of Complaint: _____ ❑ Normal ❑ Abnormal

Date of MRI/CT Scan and Where: _____ ❑ Normal ❑ Abnormal

Allergies _____

_____

_____

_____

_____

For women, are you pregnant? ❑ Yes ❑ No If yes, what is your due date? _____

Contraception Type _____

Age at First Period _____

Duration of Cycle _____

Duration of Flow _____

No. of Pregnancies _____

No. of Births _____

No. of Miscarriages _____

No. of Abortions _____

Menstral Flow: ❑ Heavy ❑ Moderate ❑ Light

Date of Last Period _____

Date of Last Pap Smear _____

Date of Last Vaginal Exam _____

Date of Last Mammogram _____

Date of Last Prostate Exam _____

Patient Name: _____ Date: _____

FAMILY HISTORY

Please select all that apply, whether past or present.

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

SOCIAL HISTORY

Please select all that apply, whether past or present.

Current Weight _____ Have you lost or gained weight recently? _____

Sports/Hobbies (i.e.tennis, golf, pickleball, fishing, etc.): _____

_____

Exercise: ❑ Heavy ❑ Moderate ❑ Light Hours per day_____

Smoking: ❑ Current ❑ Previous Packs per day_____ Number of Years _____

❑ VAPE ❑ Marijuana _____ ❑ Cigarettes ❑ Smokless/Chewing Tobacco

Alcohol: Beer/Week _____ Liquor/Week ____ Wine/Week _____ Number of years___

Caffeine: Cups per day _____ Number of years _____ *(coffee, tea, cola)*

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT USING THE FOLLOWING SYMBOLS:

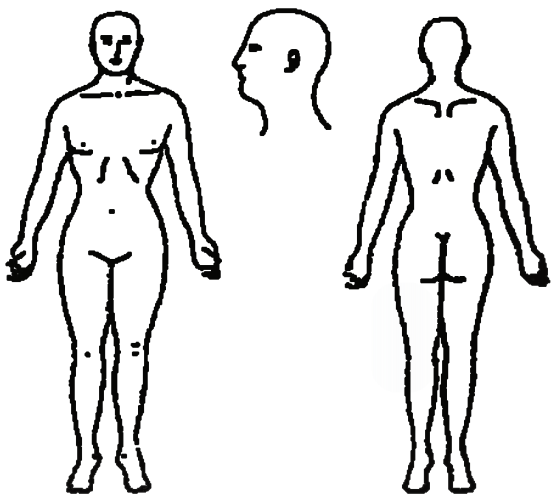
Aches ^^^^ Numbness oooo Pins/Needles •••• Stabbing ////

Try to rate your pain on average between 0 and 10:

1 2 3 4 5 6 7 8 9 10

How bad have your sypmtoms been in the past:

1 2 3 4 5 6 7 8 9 10



Patient Name:_____ Date: _____