1 WHERE DOES IT HURT?

OSC CHIROPRACTIC & SPORTS REHABILITATION

Please check the appropriate box for any of the following symptoms which you have or have had previously. It is essential for us to understand your complete medical history prior to presenting treatment.

Name _____ Date _____

(Last) (First) (Middle)

Birth date _____ Height _____ Weight _____ Sex _____

Key: O = Occasional F = Frequent C = Constant

O	F	C	General
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

O	F	C	Respiratory
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

O	F	C	Cardio-Vascular
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles

O	F	C	Skin
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

O	F	C	Muscle & Joint
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	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

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2 CONFIDENTIAL HEALTH REPORT

Key: O = Occasional F = Frequent C = Constant

O	F	C	Ears, Eyes, Nose & Throat
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	Genito-Urinary
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

O	F	C	Gastro -Intestinal
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Inability to control colon
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting blood

O	F	C	For Women Only
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle (spotting)
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

Are you pregnant? yes ☐ no ☐

Date of last period:

Last Pap Smear:

Did you ever have a positive Pap Smear?
yes ☐ no ☐

Doctor's comments:

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3 CONFIDENTIAL HEALTH REPORT

Key:
N = None L = Light M = Moderate H = Heavy

Date of Last: (approx.)	
_____	Physical examination
_____	Blood test
_____	Chest x-ray
_____	Spinal x-ray
_____	Dental x-ray
_____	Urine test

N	L	M	H	Lifestyle
☐	☐	☐	☐	Alcohol
☐	☐	☐	☐	Coffee
☐	☐	☐	☐	Tobacco
☐	☐	☐	☐	Drugs:
☐	☐	☐	☐	Exercise:

Please list any prescription drugs now taken:

Have You Ever:

- ☐ Been knocked unconscious?
- ☐ Use a crutch or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

Please list any allergies and past surgeries:

Check the following conditions you have had
Circle items that are common to other family members

☐ Alcoholism	☐ Cold Sores	☐ Fever blisters	☐ Miscarriage	☐ Rheumatic fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Scarlet fever
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Stroke
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Tuberculosis
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Polio	☐ Venereal disease

Have you ever had previous chiropractic care? yes ☐ no ☐

If yes, date of last care: _____

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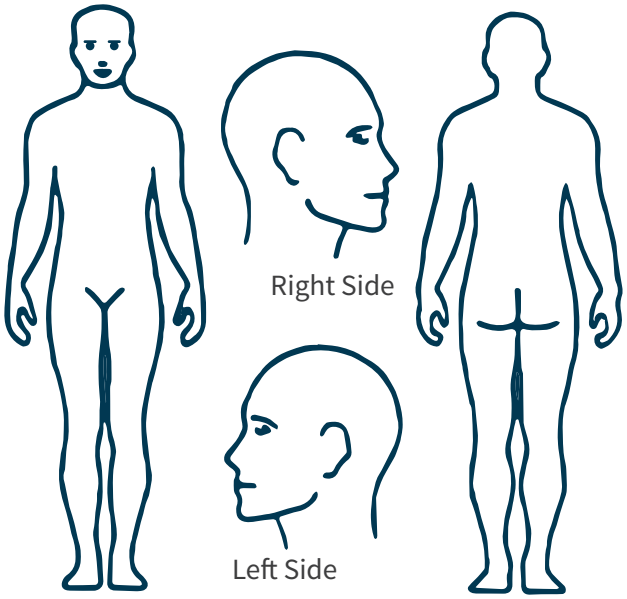
CONFIDENTIAL HEALTH REPORT

OSC CHIROPRACTIC & SPORTS REHABILITATION

Please mark your areas of pain on the figures below



Case History

Date you first noticed symptoms:

Describe major complaints and symptoms:

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Signature Date

• FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE •

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