



# New Hanover Chiropractic

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

THANK YOU.

## CONFIDENTIAL PATIENT CASE HISTORY

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Phone \_\_\_\_\_ E-Mail \_\_\_\_\_ Marital Status:  M  S  D  W

Children, Ages \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ Driver's License # \_\_\_\_\_

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? \_\_\_\_\_

Do any positions make it feel better? \_\_\_\_\_

Is this condition:  Improved  Unchanged  Getting Worse

Is this condition interfering with your:  Work  Sleep  Daily Routine  Other

Other doctors or therapists who have treated **THIS** condition \_\_\_\_\_

What do you think caused this condition? \_\_\_\_\_

\_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

\_\_\_\_\_

Do you have a family physician? Name \_\_\_\_\_

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 have NOW or have had in the PAST.

GENERAL	NOW	PAST
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>

HEAD	NOW	PAST
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam _____		
Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>

EARS	NOW	PAST
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>

THROAT	NOW	PAST
Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Masses	<input type="checkbox"/>	<input type="checkbox"/>

BREASTS	NOW	PAST
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>
Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>
Bloated	<input type="checkbox"/>	<input type="checkbox"/>

LUNGS	NOW	PAST
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Blood	<input type="checkbox"/>	<input type="checkbox"/>
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>

HEART	NOW	PAST
Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD	NOW	PAST
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>
Red Spots	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Black Stools	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL	NOW	PAST
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Facial	<input type="checkbox"/>	<input type="checkbox"/>
Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty of Speech	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNIZATION/ VACCINATION	NOW	PAST
DPT	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input type="checkbox"/>	<input type="checkbox"/>

**REVIEW OF SYSTEMS-Check only the ones you have NOW or have had in the PAST.**

GENITOURINARY	NOW	PAST
Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Straining	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Stones	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Urine Color	<input type="checkbox"/>	<input type="checkbox"/>
Spotting bet. Periods	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

Contraception Type \_\_\_\_\_  
 Age at first period \_\_\_\_\_  
 Duration of Cycle \_\_\_\_\_  
 Duration of Flow \_\_\_\_\_  
 No. Of Pregnancies \_\_\_\_\_  
 No. Of Births \_\_\_\_\_  
 No. Of Miscarriages \_\_\_\_\_  
 No. Of Abortions \_\_\_\_\_  
 Menstrual Flow – Heavy Mod. Light  
 Last Period \_\_\_\_\_  
 Last Pap Smear \_\_\_\_\_  
 Last Vaginal Exam \_\_\_\_\_  
 Last Mammogram \_\_\_\_\_  
 Last Prostate Exam \_\_\_\_\_

Blood Type \_\_\_\_\_ Blood Transfusions \_\_\_\_\_  
A+ A- Date \_\_\_\_\_  
B+ B- Date \_\_\_\_\_  
AB+ AB- Date \_\_\_\_\_  
O+ O- Date \_\_\_\_\_  
 Other \_\_\_\_\_

PSYCHIATRIC	NOW	PAST
Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>
Insecurity	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Troubled Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>
Undecidedness	<input type="checkbox"/>	<input type="checkbox"/>
Timid	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Drug Dependence	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Twitching	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>

Date of last chest X-Ray \_\_\_\_\_  
Normal Abnormal  
 Last TB Skin Test \_\_\_\_\_  
Normal Abnormal

Allergies:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Special Concerns:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST MEDICAL HISTORY-**

**Check all you have had in**

- 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
- 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

