Confidential Health History

Please fill out this questionnaire completely. Your answers will help us determine if chiropractic care can help you. If we ***do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.***

Name _____ SS# _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____ E-mail _____

Birthday _____ Age _____ M F Marital Status _____ Spouse's Name _____ No. Children _____

Occupation _____ Is your condition due to an injury at work? ☐ Yes ☐ No

Employer's Name _____ Address _____ _____

Who referred you to us? _____ Who is responsible for paying for your treatment? _____

Do you have health insurance? _____ If yes, with which insurance company? _____

Have you ever had previous chiropractic care? _____ If yes, date of last care: _____

Name of your medical doctor: _____ Address _____ _____

If we are able to accept your case, what type of care do you want? ☐ **Corrective Care** ☐ **Pain Relief Only**

Please check the appropriate box for any of the following symptoms which you have experienced. ***Only check the box if you have experienced the symptom; otherwise please leave it blank****. We need all the facts about your health history before we accept* your case. *THIS INFORMATION IS CONFIDENTIAL*

O – OCCASSIONAL **F – FREQUENT** **C - CONSTANT**

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Weight loss
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot problems
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulder blades
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Stomach pain
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE & THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum/teeth trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus problems
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Chest pain
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dry skin
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions/rashes
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control urination
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Fibrotic breasts
☐	☐	☐	Menstrual cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Vaginal discharge

Are you pregnant? Yes ☐ No ☐

Last gynecological exam: _____

Please check the following conditions you have had in the past:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Low back pain	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal Disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

The Body Connection **1S132 Summit Ave., Suite 307** **Oakbrook Terrace, IL 60181** **(630) 705-1475**

PLEASE PRINT

What health problem do you want us to treat? _____

How long have you had these symptoms? _____ Have you had similar symptoms in the past? _____

How did it happen? _____

What activities make your symptoms worse? _____

Are your symptoms getting worse? ☐ Yes ☐ No Are your symptoms: ☐ Constant ☐ They come and go

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Family or spouse relationship ☐ Other_____

What things can't you do now that you hope to be able to do after your treatments are done?

_____

_____

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for your present condition: _____

_____

What do you believe is wrong with you? _____

What other health problems do you have: _____

List any surgeries and dates: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ Heart pills ☐ Tranquilizers ☐ Antibiotics ☐ Birth control pills ☐ Others _____

How often do you go to the dentist? ☐ Every six months ☐ Yearly ☐ Toothache or emergency only

How old is your mattress? _____ Is it ☐ Comfortable? ☐ Uncomfortable?

Do you wear: ☐ Heel lifts? ☐ Inner soles? ☐ Arch supports?

Have you been in an car crash (even a "fender-bender") in the: ☐ Past year ☐ Past five years ☐ Five to ten years ago ☐ Over ten years ago ☐ Never

Please describe the crash _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No If so, when? _____ Type _____

Have others in your family had such disorders? ☐ Yes ☐ No If so, when? _____ Type _____

FAMILY HEALTH INFORMATION *(Many health problems are hereditary. Thus, information about your family members will give us a better picture of your total health picture.)*

NAME	RELATIONSHIP to YOU	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	Please describe briefly
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fractured bone?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	

DO YOU:			
Now take vitamins or minerals?	☐	☐	
Think you may need vitamins or minerals?	☐	☐	
Have an allergy to any drug?	☐	☐	

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Physical examination	☐	☐	☐	☐
Spinal examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Urine test	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

List below all conditions for which you have been treated in the past 10 years.

_____

_____

_____

_____

_____

_____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY? *(Name of relative or close friend **NOT** living with you)*:

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip _____