Kudick CHIROPRACTIC

Name _____

Date _____

Purpose of Visit _____

_____

Goal: (please check) ☐ Symptoms/Pain Relief Only ☐ Stabilize Condition ☐ Corrective Care/ Maximize Health

Do you buy bottled water? ☐ Always ☐ Usually ☐ Seldom ☐ Never

Why _____

Do you purchase healthy foods? ☐ Always ☐ Usually ☐ Seldom ☐ Never

Why _____

Do you belong to a health club? ☐ Yes ☐ No

Why _____

Do you exercise? ☐ 3 or more times per week ☐ 1-2 times per week ☐ 1-2 times per month ☐ Seldom/Never

Why _____

CONFIDENTIAL PATIENT CASE HISTORY

Last name _____ First _____ M.I._____

Mailing address _____ City _____ State_____ Zip_____

Home phone _____ Work phone _____

Date of birth_____ Age_____ M_____ F_____

Marital status_____ Number of children_____ Names _____ Ages _____

Occupation_____ Spouse_____ _____ _____

SS#_____ Referred by_____ _____ _____

Who is responsible for this account _____ _____ _____

Do you presently have any health problems or major complaint area's?

☐ No ☐ Yes, if yes, please describe_____

_____

_____

How long have you had this? _____

Has it interfered with daily activity, such as work ____home ____emotional ____sleep ____sports ____

other _____

What makes it worse? _____

What makes it better? _____

Have you had this before? _____

_____

_____

Other complaint areas_____

_____

_____

_____

_____

_____

_____

_____

CONFIDENTIAL PAST HISTORY

List surgical operations and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others _____

Dental visits: ☐ Every six months ☐ Yearly ☐ Toothache or emergency only ☐ Complete dentures

Age of mattress _____ ☐ Comfortable ☐ Uncomfortable Do you use a bed board: _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	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
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

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

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS.

_____

_____

_____

_____

_____

_____

_____

_____

_____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME _____

ADDRESS _____ PHONE _____

_____
PATIENT'S SIGNATURE

_____
DOCTOR'S SIGNATURE

Please answer carefully the following as this information can affect your overall course of chiropractic care

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Gas
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain
- ☐ Walking Problems
- ☐ Difficult Breathing
- ☐ Clicking Jaw
- ☐ General Stiffness
- ☐ Bloating After Meals
- ☐ Heatburn
- ☐ Black/Bloody Stool
- ☐ Colitis
- ☐ Stiffness

GENTO-URINARY

- ☐ Bladder Trouble
- ☐ Painful Urination
- ☐ Excessive Urination
- ☐ Discolored Urine

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heart Beat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EARS, EYES, NOSE, THROAT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulties
- ☐ Stuffed Nose

GASTO-INTESTINAL

- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Problems
- ☐ Abdominal Cramps

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain ☐ Infections
- ☐ Breast Pain ☐ Lumps
- ☐ Prostate
- ☐ Sexual Dysfunction
- ☐ H.I.V. Positive

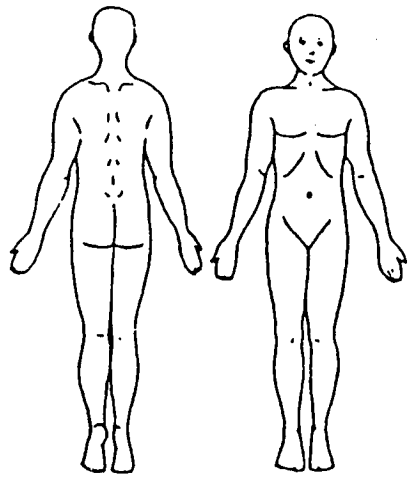
FEMALES ONLY

When was your last period?_____

Are You Pregnant?

☐ Yes ☐ No ☐ Not Sure

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF YOUR DISCOMFORT



IS YOUR PAIN:

- ☐ Constant
- ☐ Intermittent
- ☐ Occasional

IF IN PAIN, CHOOSE FROM THE FOLLOWING DESCRIPTIONS:

- ☐ Stabbing
- ☐ Throbbing
- ☐ Sharp
- ☐ Dull
- ☐ Grabbing
- ☐ Shooting
- ☐ Cramping
- ☐ Toothache
- ☐ Dull Ache

—OVER—