Date____/___/____

# CONFIDENTIAL HEALTH REPORT

Name_____ Height_____ Weight_____

Children (list ages) _____

**PLEASE LIST YOUR CURRENT AREA(S) OF COMPLAINT**

1) _____ 2) _____ 3) _____ 4) _____

**CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN** (1 = Mild, 10 = Severe)

0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

**DATE YOU FIRST NOTICED SYMPTOMS**

1)_____ 2)_____ 3)_____ 4) _____

Please check the appropriate box for any of the following symptoms which you now have or had previously. **(O= occasionally, F= frequently)**

| O | F | GENERAL |
|---|---|---|
| □ | □ | Allergy |
| □ | □ | Convulsions |
| □ | □ | Dizziness or Fainting |
| □ | □ | Headache |
| □ | □ | Neuralgia (nerve pain) |
| □ | □ | Numbness |
| | | **MUSCLE & JOINT** |
| □ | □ | Swollen joints |
| □ | □ | Arthritis |
| □ | □ | Bone fracture |
| □ | □ | Bursitis |
| □ | □ | Joint dislocation |
| □ | □ | Foot trouble |
| □ | □ | Low back pain |
| □ | □ | Neck pain or stiffness |
| □ | □ | Pain between shoulders |
| □ | □ | Sciatica |
| | | **PAIN, NUMBNESS, CRAMPS** |
| □ | □ | Shoulder Right / Left |
| □ | □ | Arm Right / Left |
| □ | □ | Elbow Right / Left |
| □ | □ | Hand Right / Left |
| □ | □ | Fingers Right / Left |
| □ | □ | Hip Right / Left |
| □ | □ | Leg Right / Left |
| □ | □ | Knee Right / Left |
| □ | □ | Foot Right / Left |
| □ | □ | Toes Right / Left |
| | | **RESPIRATORY** |
| □ | □ | Chest pain |
| □ | □ | Chronic cough |
| □ | □ | Difficult breathing |
| □ | □ | Spitting up blood |
| □ | □ | Spitting up phlegm |
| □ | □ | Wheezing |

| O | F | GASTRO-INTESTINAL |
|---|---|---|
| □ | □ | Colon trouble |
| □ | □ | Constipation |
| □ | □ | Diarrhea |
| □ | □ | Difficult digestion |
| □ | □ | Distention of abdomen |
| □ | □ | Gall bladder trouble |
| □ | □ | Hemorrhoids |
| □ | □ | Liver trouble |
| □ | □ | Pain over stomach |
| | | **EYES, EARS, NOSE, THROAT** |
| □ | □ | Asthma |
| □ | □ | Colds |
| □ | □ | Ear ache |
| □ | □ | Deafness |
| □ | □ | Ear discharge |
| □ | □ | Ear noises |
| □ | □ | Nasal obstruction |
| □ | □ | Nosebleeds |
| □ | □ | Eye pain |
| □ | □ | Sinus infection |
| | | **CARDIOVASCULAR** |
| □ | □ | Hardening of arteries |
| □ | □ | High Blood Pressure |
| □ | □ | Low Blood Pressure |
| □ | □ | Pain over heart |
| □ | □ | Poor circulation |
| □ | □ | Rapid heartbeat |
| □ | □ | Slow heartbeat |
| □ | □ | Swelling in ankles |
| | | **SKIN** |
| □ | □ | Bruise easily |
| □ | □ | Dryness |
| □ | □ | Skin eruptions (rash) |
| □ | □ | Varicose veins |

| O | F | GENITO-URINARY |
|---|---|---|
| □ | □ | Bed-wetting |
| □ | □ | Blood in urine |
| □ | □ | Frequent urination |
| □ | □ | Inability to control bladder |
| □ | □ | Kidney infection or stones |
| □ | □ | Painful urination |
| □ | □ | Prostate trouble |
| □ | □ | Pus in urine |

**DATE OF LAST (approx):**

Physical Exam _____
Blood Test _____
Chest X-ray _____
Spinal X-ray _____
Dental X-ray _____
Urine Test _____

| O | F | FOR WOMEN ONLY |
|---|---|---|
| □ | □ | Congested breasts |
| □ | □ | Lump(s) in breast |
| □ | □ | Cramps or backache |
| □ | □ | Vaginal discharge |
| □ | □ | Irregular cycle |
| □ | □ | Excessive menstrual flow |
| □ | □ | Painful menstruation |
| □ | □ | Hot flashes |
| □ | □ | Menopausal symptoms |

Previous miscarriage(s) □ yes □ no
Pregnant □ yes □ no
Date of last period_____

**PLEASE CIRCLE YOUR USE OF THE FOLLOWING:**

| | | | | |
|---|---|---|---|---|
| Alcohol consumption | none | light | moderate | heavy |
| Coffee | none | light | moderate | heavy |
| Tobacco/Drugs | none | light | moderate | heavy |
| Exercise | none | light | moderate | heavy |
| Soft drinks | none | light | moderate | heavy |

**HAVE YOU EVER:**

□ been knocked unconscious
□ used a crutch or support
□ been treated for spine or nerve disorder
□ fractured a bone _____
□ been hospitalized for something non-surgical

**Please list any surgeries:** _____

_____

**Please list any prescriptions:**_____

_____

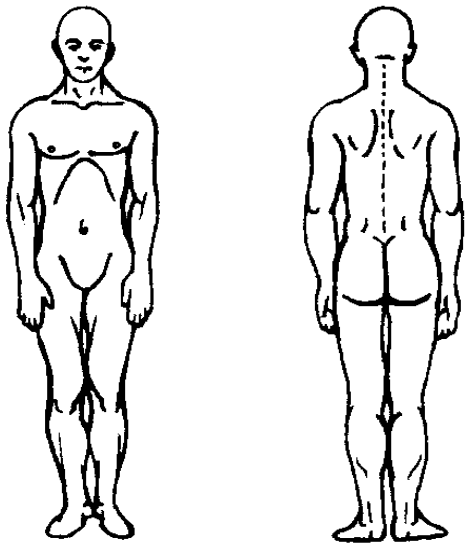
**over** →

**PLACE "S" (self) or "F" (family) BY THE FOLLOWING CONDITIONS YOU OR A FAMILY MEMBER HAVE OR HAVE HAD**

| | | | | | |
|---|---|---|---|---|---|
| _____AIDS | _____Cancer | _____Foot Problems | _____HIV/ARC | _____Osteoporosis | ____Stroke |
| _____Alcoholism | _____Chicken Pox | _____Goiter | _____Malaria | _____Pace maker | ____Thyroid Trouble |
| _____Anemia | _____Diabetes | _____Gout | _____Measles | _____Pneumonia | ____Ulcers |
| _____Appendicitis | _____Emphysema | _____Emotional Prob. | _____Multiple Sclerosis | _____Polio | ____ Venereal Disease |
| _____Arteriosclerosis | _____Epilepsy | _____Heart Disease | _____Mumps | _____Rheumatic Fever | |

**PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:**

| | |
|---|---|
| Dull | = D |
| Aching | = A |
| Stiffness | = S |
| Burning | = B |
| Tingling | = T |
| Numbness | = N |
| Sharp | = !!! |
| Shooting | = XXX |
| Other_____ | = *** |



How often do you notice your symptoms? Constantly / Frequently / Occasionally

Does anything provide relief?_____

What activities are difficult to perform? Sitting / Standing / Walking / Bending / Lying Down / Other: _____

_____

Please describe any other activities that are restricted:_____

_____

The condition is: getting worse / staying the same / getting better

Have you had this problem before? No / Yes When?_____

Have you had an injury, fall or accident? No / Yes Describe:_____

_____

Have you ever: Been to a Chiropractor before? No / Yes Been to a Gonstead Chiropractor before? No / Yes

How was your experience? _____

Which best describes your health goals: pain relief only correct entire problem wellness/ preventative care

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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_____/_____/_____

Patient name (if minor)_____