

Conforti Chiropractic and Wellness Center, Inc.

4040 Tampa Road • Oldsmar, FL 34677

813-818-7499 • (fax) 813-818-7239

CONFIDENTIAL PATIENT CASE HISTORY

PLEASE COMPLETE THIS QUESTIONNAIRE. THIS CONFIDENTIAL HISTORY WILL BE PART OF YOUR PERMANENT RECORDS. THANK YOU.

Name _____ Birthday _____ Sex M F

Address _____ City _____ Zip _____

Soc. Sec. # ____ - ____ - ____ Home Phone (____) _____ Work (____) _____ Cell (____) _____

Marital Status: M S D W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

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 _____ MAY WE CONTACT _____

Medications, dosage and frequency: _____

Have you been in an auto accident or had any other personal injury? Y N Describe: _____

HAVE YOU EVER BEEN TO A CHIROPRACTOR IN THE PAST? ____ How long Ago? ____ What were the results? _____

WHAT IS THE GOAL THAT YOU WOULD LIKE TO HELP YOU ACHIEVE? (CHECK ALL THAT APPLY)

- PAIN RELIEF.
- CORRECT THE CAUSE OF PAIN.
- WELLNESS CARE TO ENSURE THAT THE CAUSE DOES NOT RETURN.

PATIENT NAME _____

SIGNATURE _____ DATE _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

GENERAL	NOW	PAST	THROAT	NOW	PAST	GASTROINTESTINAL	NOW	PAST
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
SKIN			NECK			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>				Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>				Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
HEAD						Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>				GENITOURINARY		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>				Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>				Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam _____						Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>				Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HEART			Urine Color _____		
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between		
NOSE			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Periods	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD					
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>			
MOUTH			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>			
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>			
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>			
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Period _____		
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear _____		
						Last Mammogram _____		
						Last Prostate Exam _____		

NAME _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per week _____ Type _____

Smoking Current Previous Packs/Day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine (Coffee, Tea, Cola) Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.

Use the following symbols:

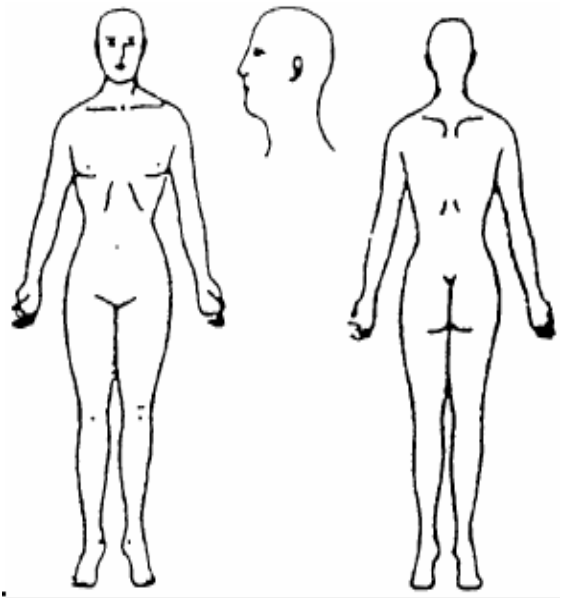
Aches ^^^^ Numbness oooo Pins/Needles Stabbing ////

MARK AN "X" ON THE LINES:

- How bad are your symptoms **now**?

 None _____ Most Severe
- How bad have they been **in the past**?

 None _____ Most Severe



Patient Name _____ Date _____