Coria
Natural Health Clinic

Confidential Patient Case History – PLEASE PRINT

Name _____ Date_____

What is your major complaint? _____

_____

_____

_____

Other complaints _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition?_____

Is this condition getting progressively worse? ____Yes ____ No ____ Constant ____ Comes and goes

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

Please check all of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff.

GENERAL SYMPTOMS

____ Asthma
____ Headache
____ Allergies
____ Migraine
____ Tension
____ Fever
____ Chills
____ Sweats
____ Fainting
____ Dizziness
____ Convulsions
____ Loss of sleep
____ Fatigue
____ Nervousness
____ Loss of weight
____ Obesity
____ Numbness or pain in arms, hands, legs
____ Wheezing
____ Neuralgia

____ Poor Circulation
____ Dental decay
____ Gum Trouble
____ Frequent colds
____ Enlarged Thyroid
____ Tonsillitis
____ Sinus infection
____ Nasal drainage
____ Enlarged glands

SKIN

____ Skin eruptions
____ Psoriasis
____ Eczema
____ Itching
____ Bruises easily
____ Dryness
____ Varicose veins
____ Sensitive skin
____ Hives or allergy

EARS, EYES, NOSE THROAT

____ Failing vision
____ Nearsightedness
____ Farsightedness
____ Crossed eyes
____ Eye pain
____ Deafness
____ Earache
____ Ear noises
____ Ear discharge
____ Nose bleeds
____ Nasal Obstruction
____ Sore throat
____ Hoarseness
____ Hay fever

RESPIRATORY

____ Chronic cough
____ Spitting up phlegm
____ Spitting up blood
____ Chest pain
____ Difficult breathing

CARDIO-VASCULAR

____ Rapid beating heart
____ Slow beating heart
____ High blood pressure
____ Low blood pressure
____ Pain over heart
____ Previous heart stroke
____ Hardening of arteries
____ Swelling of ankles
____ Paralytic stroke

MUSCLE & JOINT SYMPTOMS

____ Arthritis
____ Stiff neck
____ Back ache
____ Swollen joints
____ Tremors
____ Painful joints
____ Painful tailbone
____ Foot trouble
____ Pain between shoulders
____ Hernia
____ Spinal curvature
____ Faulty posture
____ Muscle spasms
____ Back spasms
____ Sciatica

GENITO-URINARY SYMPTOMS

____ Frequent urination
____ Painful urination
____ Blood in urine
____ Pus in urine
____ Kidney infection or stone
____ Bed wetting
____ Inability to control urine
____ Prostate trouble

GASTRO-INTESTINAL SYMPTOMS

____ Poor appetite
____ Difficult digestion
____ Excessive Hunger
____ Belching or Gas
____ Nausea
____ Vomiting
____ Vomiting blood
____ Pain over stomach
____ Distension of abdomen
____ Constipation
____ Diarrhea
____ Colon trouble
____ Hemorrhoids (piles)
____ Liver trouble
____ Gall bladder trouble
____ Jaundice
____ Colitis

FOR WOMEN ONLY

____ Painful menstrual periods
____ Excessive flow
____ Hot flashes
____ Irregular cycle
____ Cramps or backache
____ Previous miscarriage
____ Vaginal discharge
____ Congested breast
____ Lumps in breast
____ Menopausal symptoms

Have you ever had previous chiropractic care? ____ If Yes, date of last care _____

Medical Attention for Chief Complaint:

Name of doctor _____ Clinic Name _____

When attended, how long, hospitalization? _____

Examinations and x-rays made _____

Diagnosis _____

Type and duration of treatment _____

Result of treatment: ____ Good ____ Fair ____ Poor _____

Previous Chiropractic History

Name of doctor _____ Clinic Name _____

What were you treated for? _____

Examinations and x-rays made _____

Cause of problem as explained by doctor _____

Treatment type and duration _____

Result of treatment: ____ Good ____ Fair ____ Poor _____

List surgical operations and years _____

Medications you are currently taking: ____ Nerve pills ____ Pain killers ____Muscle relaxers ____ Stimulants ____ Tranquilizers

____ Insulin ____ Birth control pills Other _____

Have you been in an auto accident? ____ Past Year ____ Past 5 years ____ Over 5 years ____ Never

Describe _____

Have you had any other personal injury or accident? ____ Past Year ____ Past 5 years ____ Over 5 years ____ Never

Describe _____

Have you ever been knocked unconscious or stunned? ____ No ____ Yes When and how? _____

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

Relation	Age	Present Symptoms	Previous Serious Illness.

HAVE YOU EVER	**YES**	**NO**	**DESCRIBE BRIEFLY**
Been treated for a spine or nerve disorder?	____	____	_____
Had a fractured bone?	____	____	_____
Been hospitalized for other than surgery?	____	____	_____
Been diagnosed as having Hepatitis (A or B)?	____	____	_____
Been diagnosed as having Aids?	____	____	_____
Been diagnosed as having Mumps?	____	____	_____
Been diagnosed as having Measles?	____	____	_____
Been diagnosed as having Chicken Pox?	____	____	_____

DO YOU:

Now take vitamins or minerals?	____	____	_____
Think you may need vitamins or minerals?	____	____	_____
Have an allergy to any drug?	____	____	_____

HABITS:	Heavy	Moderate	Light	None	List all conditions for which you've received treatment in the last 10 years:
Alcohol	_____	_____	_____	_____	_____
Coffee	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Drugs	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____
Sleep	_____	_____	_____	_____	_____
Appetite	_____	_____	_____	_____	_____

Signature of Patient _____ Date _____