



**BULLDOG CHIROPRACTIC
INFORMATION FOR CARE**

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist.

PLEASE PRINT CLEARLY

Name _____ Today's Date _____

Address _____ City-State-Zip _____

Home # _____ Cell # _____ Male _____ Female _____

Age _____ DOB _____ SS# _____

E-mail Address _____ Your Signature _____

Marital Status: S M W D Number of Children _____

How did you hear about us _____

Your Employer _____ Occupation _____

Yrs. On Job _____ Employer Address _____

City-State-Zip _____

Office Phone Number _____

Insurance Company _____

Do you have Medicare? Yes _____ No _____

Do you have Medicaid? Yes _____ No _____

Name of Spouse or Parent _____ DOB _____

Spouse employed by _____ Occupation _____

Yrs. On Job _____ Employer Address _____

City-State-Zip _____

Office Phone- _____ Spouse SS# _____

Does your spouse have health insurance at work? Yes _____ No _____

Is your condition due to an accident? Yes _____ No _____

If yes date of accident _____

Type of accident? Auto _____ Work _____ Home _____ Other _____

Have you ever been in an Auto Accident? Past Year _____

Past 5 years _____ Over 5 Years _____ Never _____

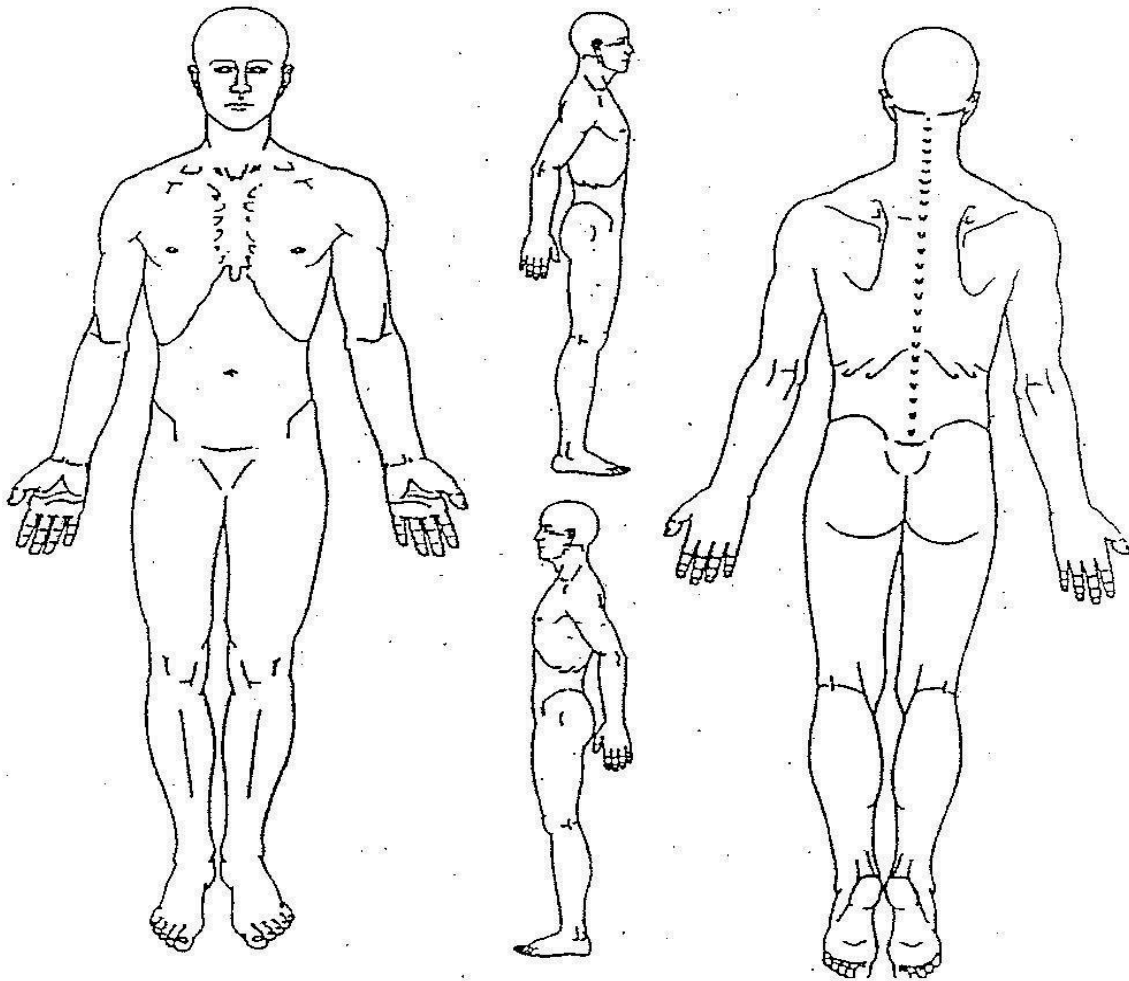
NAME (please print) _____

AGE _____ DATE OF BIRTH _____

OCCUPATION _____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW.

A=PAIN B=BURNING C=NUMBNESS
P=PINS AND NEEDLES S=STABBING
O=OTHER



Your Signature _____

**BULLDOG CHIROPRACTIC
CONFIDENTIAL PATIENT
CASE HISTORY**

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Thank You.....

Name _____ Date _____

Please check the appropriate box for any of the following symptoms, which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS CONFIDENTIAL REPORT.

Please enter “2” for Previously and “3” for Presently in front of all of the following signs and symptoms. Leave blank if not applicable.

General Symptoms

- Headaches
- Fever
- Chills
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Loss of Weight
- Numbness or pain
- Allergy
- Wheezing
- Neuralgia

Muscles & Joints

- Weakness
- Twitching
- Stiff Neck
- Backache
- Swollen Joints
- Painful Tailbone
- Pain between Shoulder
- Spinal Curvature
- Arthritis
- Bursitis
- Hernia
- Lumbago

Pain or numbness in:

- Arms
- Hands
- Hips
- Legs
- Feet
- Knees

Your Signature _____

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CASE HISTORY

Gastro-Intestinal

- Poor Appetite
- Poor Digestion
- Belching or Gas
- Nausea
- Vomiting
- Stomach Pain
- Constipation
- Diarrhea
- Hemorrhoids
- Fluid Retention
- Liver Trouble
- Gout
- Gallbladder Trouble
- Colitis

Respiratory

- Chronic Cough
- Spitting Blood
- Phlegm
- Chest Pain
- Difficulty Breathing
- Asthma

Skin

- Skin Eruptions
- Itching
- Bruising Easily
- Dryness
- Boils
- Sensitive Skin
- Hives
- Eczema

Urinary Genito

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Infections
- Kidney Stones
- Bed Wetting
- Inability to control Bladder
- Prostate Trouble

Cardiovascular

- Rapid Heart Rate
- Slow Heart Rate
- High Blood Pressure
- Low Blood Pressure
- Heart Palpitations
- Swelling Ankles
- Poor Circulation
- Heart Trouble
- Varicose Veins
- Strokes
- Hardening of Arteries

Eyes/Ears/Nose/Throat

- Poor Vision
- Eye pain
- Deafness
- Earache
- Ear Ringing
- Ear Discharge
- Nasal Obstruction
- Nose Bleeds
- Sore Throat
- Hoarseness
- Hay Fever
- Enlarged Thyroid
- Tonsilitis
- Sinus Trouble
- Dental Decay
- Gum Trouble

For Women Only

- Painful Periods
- Excessive Flow
- Irregular Cycle
- Hot Flashes
- Cramps
- Vaginal Discharge

Are you pregnant at this time?

- Yes
- No

Your Signature _____

PLEASE CHECK THE FOLLOWING CONDITIONS
YOU HAVE HAD:

- | | | |
|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Malaria | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chorea | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Tubes in Ears |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Back Operation |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sinus Surgery |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Lumbago | <input type="checkbox"/> Polio | <input type="checkbox"/> Female Organs
(Removed) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic Fever | |

Please List All Medications you are now taking:

What is your major complaint?

List Surgical operations and years:

Hospital Stays: _____

List any accidents or falls/ list dates:

Car _____

School _____

Sports _____

Other _____

Your Signature _____

CASE HISTORY

Have you ever been knocked unconscious? ___ Yes ___ No

Used a cane, crutch, or other support? ___ Yes ___ No

Been treated for a spine or nerve disorder? ___ Yes ___ No

Had a fractured bone? ___ Yes ___ No

Do you take vitamins or minerals? ___ Yes ___ No

Date of Last:

Spinal Exam ___ less than 6 months ___ 6-18 months ___ Never

Physical Exam ___ less than 6 months ___ 6-18 months ___ Never

Blood Test ___ less than 6 months ___ 6-18 months ___ Never

Chest X-Ray ___ less than 6 months ___ 6-18 months ___ Never

Spinal X-Ray ___ less than 6 months ___ 6-18 months ___ Never

Habits

Alcohol ___ Heavy ___ Moderate ___ Light ___ None

Coffee ___ Heavy ___ Moderate ___ Light ___ None

Tobacco ___ Heavy ___ Moderate ___ Light ___ None

Drugs ___ Heavy ___ Moderate ___ Light ___ None

Exercise ___ Heavy ___ Moderate ___ Light ___ None

Sleep ___ Heavy ___ Moderate ___ Light ___ None

Appetite ___ Heavy ___ Moderate ___ Light ___ None

Your Signature _____