Alvey Chiropractic

Patient Case History

Patient Name: _____ Date: _____

Address: _____ City: _____

Home phone: _____ Cell Phone: _____ Carrier: _____

Date of Birth: _____ Age: _____ S.S.#: _____

Email: _____ Referred by: _____

Occupation: _____ Employer: _____

Are there any condition(s) your primary physician treating you for currently?

_____

_____

What medications are you taking currently? (You may submit a list)

_____

_____

Please list previous surgeries: _____

_____

Do you have any allergies? _____

Are you pregnant now? Yes No How many children do you have ? _____
Were any births C-section? No Yes #_____

Do you smoke? Yes No If yes, how much? _____
Do you drink alcohol? Yes No □ Casually □ Daily □ Weekly □ Once in a while

Level of education: □ high school □ some college □ college graduate □ post graduate

How often do you exercise? □ Daily □ 3x week □ 2x week □ 1x week □ I don't exercise

What nutritional supplements do you take regularly? _____
What is your main complaint? _____
Does it radiate to another body part? If so, where? _____
What do you think caused the main complaint? _____
When did your complaint begin? _____

Patient Signature_____

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Health / Family History *Circle any conditions that currently apply*

General fainting chills convulsions depression dizziness loss of weight fatigue fever headache loss of sleep weight gain neuralgia night sweats wheezing nervousness

Gastro-Intestinal constipation diarrhea gall bladder issues hemorrhoids jaundice nausea liver problems stomach pain poor appetite poor digestion

Ear Nose & Throat crossed eyes deafness earache ear discharge ear noises enlarged thyroid frequent colds hay fever hoarseness nasal obstruction nose bleeds pain in eyes poor vision sinusitis sore throat tonsillitis

Respiratory asthma chest pain chronic cough difficulty breathing spitting blood spitting phlegm

Muscles/Joints/Bones backache foot problems pain between shoulder blades painful tailbone stiff neck spinal curvature swollen joints tremors twitching weakness

Cardiovascular ankle swelling high blood pressure low blood pressure heart trouble pain over heart poor circulation rapid heart slow heart strokes

Skin /Allergies bruise easily dryness eczema hives itching

Women cramps excessive flow hot flashes irregular cycle painful periods

Do you have a pacemaker? **Yes No Family doctor** _____

Family History : Mark the following conditions as they apply

Condition	You	Mother	Father	Sister	Brother
Diabetes					
Heart Issues					
Kidney Issues					
Cancer					
Headaches					
Back Pain					
Obesity					

If cancer, what type? _____

Patient Signature:

_____