



We've Got Your Back

1076 E. Bethlehem Blvd, Wheeling, WV 26003 | 304-243-1055 | www.nardonechiropractic.com

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 \_\_\_\_\_ E-Mail \_\_\_\_\_

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 therapist who have treated THIS condition \_\_\_\_\_

What do you think caused this condition? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Do you have a family physician? Name \_\_\_\_\_

Medications, dosage and frequency: \_\_\_\_\_

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_ 1

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

<u>GENERAL</u>	NOW	PAST	<u>THROAT</u>	NOW	PAST	<u>GASTROINTESTINAL</u>	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"/>	Heatburn	<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"/>
<u>SKIN</u>			<u>NECK</u>			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"/>	<u>BREASTS</u>			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEAD</u>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<u>LUNGS</u>			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"/>
<u>EARS</u>			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"/>	<u>HEART</u>			Urine Color _____		
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between		
<u>NOSE</u>			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"/>	Contraception Type _____		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<u>BLOOD</u>			Age of First Period _____		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Cycle _____		
<u>MOUTH</u>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow _____		
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies _____		
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births _____		
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages _____		
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions _____		
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow <input type="checkbox"/> Hvy. <input type="checkbox"/> Mod. <input type="checkbox"/> Lt.		
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Period _____		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear _____		
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam _____		
						Last Mammogram _____		
						Last Prostate Exam _____		

NAME \_\_\_\_\_

Patient Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

**NEUROLOGIC**

	NOW	PAST
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Facial	<input type="checkbox"/>	<input type="checkbox"/>
Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Speech	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>

**ENDOCRINE**

Wright Loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>

**IMMUNIZATION/VACCINATION**

DPT	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>
Tetnus	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input type="checkbox"/>	<input type="checkbox"/>

**BLOOD TYPE**

A+	<input type="checkbox"/>	A-	<input type="checkbox"/>
B+	<input type="checkbox"/>	B-	<input type="checkbox"/>
AB+	<input type="checkbox"/>	AB-	<input type="checkbox"/>
O+	<input type="checkbox"/>	O-	<input type="checkbox"/>
Other	_____		

**BLOOD TRANSFUSIONS**

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

**PSYCHIATRIC**

	NOW	PAST
Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>
Insecurity	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>
Undecidedness	<input type="checkbox"/>	<input type="checkbox"/>
Timid	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addicaiion	<input type="checkbox"/>	<input type="checkbox"/>
Drug Dependent	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

**MUSCULOSKELETAL**

	NOW	PAST
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Twitching	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>

**PAST MEDICAL HISTORY. Check only the ones you have had in the past.**

Hay Fever	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	Patalysis	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Angina	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Tumber	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	Gout	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>
Skin Trouble	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	Kidney Infections	<input type="checkbox"/>
Liver Trouble	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>
Patasites	<input type="checkbox"/>	Dysentery	<input type="checkbox"/>

Date of Last Chest X-Ray \_\_\_\_\_  Normal  Abnormal

Last TB Skin Test \_\_\_\_\_  Normal  Abnormal

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 AREA OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.**

Use the following symbols:

Aches **AAAA** Numbness **oooo** Pins/Needles **.....** Stabbing **////**

**MARK AN "X" ON THE LINES:**

How bad are your symptoms now?

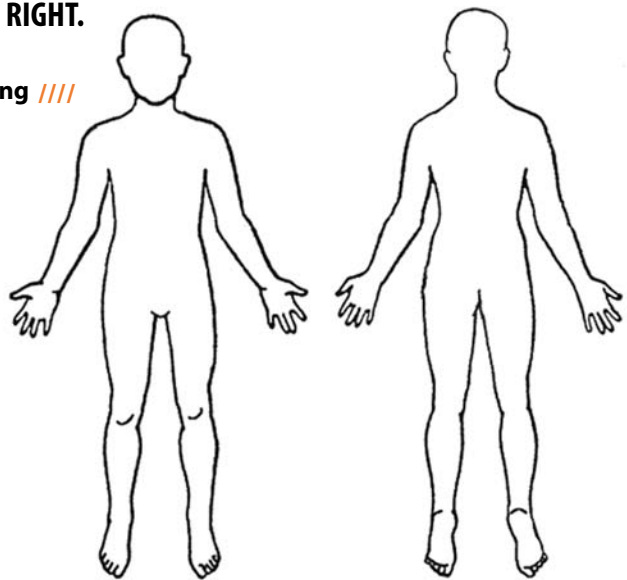
\_\_\_\_\_

None Most Severe

How bad have they been in the past?

\_\_\_\_\_

None Most Severe



Patient Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_ 4