Dear Patient: 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.

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

<table>
<thead>
<tr>
<th>O</th>
<th>F</th>
<th>C</th>
<th>GASTRO-INTESTINAL</th>
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<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Belching or gas</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Colitis</td>
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<td>☐</td>
<td>Colon trouble</td>
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<td>☐</td>
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<td>☐</td>
<td>Constipation</td>
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<td>☐</td>
<td>Diarrhea</td>
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<td>☐</td>
<td>Difficult digestion</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Distension of abdomen</td>
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<td>☐</td>
<td>Gall bladder trouble</td>
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<td>☐</td>
<td>Hemorrhoids</td>
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<td>☐</td>
<td>Nausea</td>
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<td>☐</td>
<td>Pain over stomach</td>
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<td>☐</td>
<td>☐</td>
<td>Poor appetite</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Vomiting</td>
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</tbody>
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<thead>
<tr>
<th>O</th>
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<th>RESPIRATORY</th>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Asthma</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Colds</td>
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<td>☐</td>
<td>Crossed eyes</td>
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<td>☐</td>
<td>Earache</td>
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<td>☐</td>
<td>Ear noises</td>
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<td>☐</td>
<td>Enlarged glands</td>
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<td>Gum trouble</td>
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<td>☐</td>
<td>Hay fever</td>
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<td>Ringing in ears</td>
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<td>Sinus infection</td>
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<td>Sore throat</td>
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<td>☐</td>
<td>Hardening of arteries</td>
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<td>☐</td>
<td>High blood pressure</td>
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<tr>
<td>☐</td>
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<td>☐</td>
<td>Low blood pressure</td>
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<td>☐</td>
<td>High Cholesterol</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Low/high blood sugar</td>
</tr>
</tbody>
</table>

We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No

CONFIDENTIAL PATIENT CASE HISTORY

Please list all your reasons for visiting our office:

1.
2.
3.
4.
5.
6.

List Chiropractors you have seen before:

1. Name: ___________________________ When visited: ___________________________
2. Name: ___________________________ When visited: ___________________________

List Medical Doctors consulted within the past year:

1. Name: ___________________________ Reason for visit: ___________________________
2. Name: ___________________________ Reason for visit: ___________________________

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 A CONFIDENTIAL HEALTH REPORT

O = OCCASIONAL
F = FREQUENT
C = CONSTANT

1. ☐ Allergy
2. ☐ Vertigo
3. ☐ Fatigue
4. ☐ Fever
5. ☐ Headache
6. ☐ Loss of sleep
7. ☐ Nervousness/depression
8. ☐ Numbness
9. ☐ Sweats
10. ☐ Tremors

MUSCLE AND JOINT

1. ☐ Arthritis
2. ☐ Low back pain
3. ☐ Neck pain or stiffness
4. ☐ Pain between shoulders
5. ☐ Pain or numbness in:
6. ☐ Shoulders
7. ☐ Arms
8. ☐ Elbows
9. ☐ Hands
10. ☐ Hips
11. ☐ Legs
12. ☐ Knees
13. ☐ Feet
14. ☐ Sciatica
15. ☐ Swollen joints

Team Health Care Clinic, P.C.     12217 Champlin Drive     Champlin MN 55316     763-323-1492     fax 763-422-1657
www.teamhealthcareclinic.com
CONFIDENTIAL PATIENT CASE HISTORY PAGE TWO

NAME ___________________________ DATE __________________

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD

☐ ADD/ADHD
☐ Alcoholism
☐ Alzheimer’s
☐ Anemia
☐ Cancer
☐ Celiac/Gluten disease
☐ Depression/Anxiety
☐ Diabetes
☐ Eczema
☐ Emphysema
☐ Epilepsy/Seizures
☐ Fibromyalgia
☐ Goiter
☐ Gout
☐ Heart disease
☐ Hepatitis
☐ HIV/AIDS
☐ Influenza/Flu
☐ Lyme disease
☐ Lupus
☐ Migraine
☐ Multiple sclerosis
☐ Parkinson’s
☐ Pneumonia
☐ Polio
☐ Raynaud’s
☐ Rheumatoid Arthritis
☐ Stroke
☐ Thyroid problems
☐ Ulcers
☐ Venereal disease
☐ Whooping cough

Please check all of the following conditions your family has experienced:

Mother: _______ Alzheimer’s _______ Cancer _______ Diabetes _______ Heart Disease _______ Parkinson’s _______ MS _______ Stroke
Father: _______ Alzheimer’s _______ Cancer _______ Diabetes _______ Heart Disease _______ Parkinson’s _______ MS _______ Stroke
Grandmother (M): _______ Alzheimer’s _______ Cancer _______ Diabetes _______ Heart Disease _______ Parkinson’s _______ MS _______ Stroke
Grandfather (M): _______ Alzheimer’s _______ Cancer _______ Diabetes _______ Heart Disease _______ Parkinson’s _______ MS _______ Stroke
Grandmother (P): _______ Alzheimer’s _______ Cancer _______ Diabetes _______ Heart Disease _______ Parkinson’s _______ MS _______ Stroke
Grandfather (P): _______ Alzheimer’s _______ Cancer _______ Diabetes _______ Heart Disease _______ Parkinson’s _______ MS _______ Stroke
Sisters: _______ Alzheimer’s _______ Cancer _______ Diabetes _______ Heart Disease _______ Parkinson’s _______ MS _______ Stroke
Brothers: _______ Alzheimer’s _______ Cancer _______ Diabetes _______ Heart Disease _______ Parkinson’s _______ MS _______ Stroke

List any other health conditions that you or your family have had that are not listed: __________________________________________

Do you consume any of the following? (leave blank what doesn’t apply)
Tobacco products (packs/day) _______ How many years? _______ Alcohol drinks/day _______ How many years? _______
Coffee/Tea cups/day _______ Regular or decaf? _______ Soft drinks # day _______ Regular or diet? _______

Do you use artificial sweeteners _______ yes _______ No If yes please list: ________________________________

Level of exercise _______ None _______ Moderate (days per week) _______ Strenuous (days per week) _______

Have you experienced any unexplained or rapid weight changes in the last six months? _______ Yes _______ No _______ lbs

List ALL medications and nutritional supplements you take. (Prescriptions and over-the-counter. Use additional pages if needed)

Drug name: ___________________________ Dosage: ___________________________ Supplement name: ___________________________ Dosage: ___________________________

_________________________________________ ___________________________________________ ___________________________________________

_________________________________________ ___________________________________________ ___________________________________________

_________________________________________ ___________________________________________ ___________________________________________

_________________________________________ ___________________________________________ ___________________________________________

_________________________________________ ___________________________________________ ___________________________________________

Please mark off the areas of your complaint on the diagram below. Use the following symbols:
P=pain, N=numbness, T=tingling, B=burning, C=cramping, S=stiffness