Edwards Holistic Health Center
Dr. Elva Edwards • Chiropractor
3500 South Wadsworth Blvd
Lakewood, CO 80235 • 303-980-4001
www.DrElvaEdwards.com
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Confidential Patient Case History

Please complete this questionnaire. If the doctor does not feel your condition will respond to her care, she will not accept your case.

NAME_____DATE_____
ADDRESS_____CITY_____STATE_____ZIP_____
HOME PHONE_____WORK PHONE_____
DATE OF BIRTH_____AGE____M___F___MARITAL STATUS_____ No. of CHILDREN_____
OCCUPATION_____SS#_____SPOUSE_____
e-mail: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____REFERRED BY_____

What is your major complaint?_____
How did it happen?_____
Is this an on the job injury? YES NO
Have you missed work from this illness? YES NO Dates missed?_____
Other Complaints:_____
How long have you had this condition?_____Have you had this before?_____
What activities aggravate your condition?_____
Is this getting progressively worse? YES NO CONSTANT COMES AND GOES
Is this condition interfering with your: WORK SLEEP DAILY ROUTINE OTHER
How long has it been since you really felt well?_____
List previous diagnoses and treatments you have received for your present condition:

_____
What do you believe is wrong with you?_____
List surgical operations and years:_____
_____
Auto Accidents: (when and list injuries)_____
_____
Hospitalizations: (when and why)_____
_____

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Recent dental work? (what and when)_____

Previous Chiropractic Care? (when and where)_____

Have you had x-rays within the last year?_____

Height_____Weight_____

CIRCLE IF YOU PRESENTLY HAVE OR HAVE HAD:

Dizziness	Nervousness	Foot Problems	Anemia
Low Blood Sugar	Depression	Difficult Digestion	Fainting
Undue Fatigue	Numbness	Enlarged Glands	Alcoholism
Cancer	Painful Tail Bone	High Blood Pressure	Arthritis
Broken Bones	Diabetes	Epilepsy	Asthma

FOR WOMEN ONLY:

Congested Breasts	Excessive Flow	Lumps in Breast	Hot Flashes
Vaginal Discharge	Menopausal Symptoms	Irregular Cycle	Cramps
Painful Menstruation		Are you pregnant? YES NO	

What are the illnesses in your family history?_____

_____

List any and all prescription drugs you are taking: _____

_____

Habits: (times per week)

Alcohol_____

Coffee_____

Tobacco_____

Drugs_____

List all conditions for which you have been treated in the past 10 years:

_____

_____

_____

Additional information you want the doctor to know about:_____

_____

_____

_____