Case History

Name____ Date______________
Age_________ Date of Birth______________ Sex: M F Domestic status___________________________
Street address____
Home telephone ____________________ Work telephone ___________________ Cell phone____________________
Social Security number_____________________________ Driver's license #_______________________________
Occupation/Profession _____________________________ Employer _____________________________________
Email____ Spouse's name _________________________________
Spouse's employer________________________________ Spouse's work number____________________________

Referred by____
Doctor's name____Office telephone ___________________
Street address_______________________________________City______________________State______Zip_________

Do you suffer from any condition other than that for which you are now consulting us?___________________________
Are your present problems due to an injury? ☐ No ☐ Yes ☐ On the job ☐Auto accident ☐ Personal injury ☐Other
Have you made a report of your accident? ☐ No ☐ Yes ☐ To employer ☐ Auto carrier ☐ Worker's Comp
Are you now or have you ever been disabled? (Service or work?) ☐ No ☐ Yes
When____________________________
Have you retained an attorney? ☐ No ☐ Yes Name and address ____
____

List any accidents or falls and dates: ☐ Car _________ ☐ Recreational Vehicle _________ ☐ Sports________________
☐School_________☐ Other____
List any broken bones (fractures) or dislocations____
Ever on crutches? ☐ No ☐ Yes Why? ____
Have you had any spinal taps or spinal injections? ☐ No ☐ Yes Were you ever knocked unconscious? ☐No ☐Yes
Have you ever had a lapse of memory? ☐ No ☐ Yes ☐ Don't remember
Have you had x-rays taken? ☐ No ☐ Yes When?______________ By whom?_________________________
For what ailment were these x-rays taken?____

HABITS		EXERCISE
☐ Smoking	Packs/Day _________	☐ None
☐ Drinking	Alcohol __________	☐ Moderate
☐ Coffee	Cups/Day __________	☐ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, #of__	☐	☐	☐	☐	☐
Sister, #of ___	☐	☐	☐	☐	☐

Are you using any medications? ____
____
What types of nutritional supplements do you use? ____
____

OPERATIONS AND PROCEDURES

	DATE		DATE		DATE
Vaccinations	______________	Tubes in ears	_______________	Sinus	_______________
Tonsillectomy	______________	Appendectomy	_______________	Hernia	_______________
Gall Bladder	______________	Female organs	_______________	Thyroid	_______________
Back operation	______________	Rectal surgery	_______________	Stomach	________________
Other	______________	Other	_______________	Other	_______________

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

___ Appendicitis
___ Pneumonia
___ Rheumatic fever
___ Polio
___ Tuberculosis
___ Whooping cough

___ Chicken Pox
___ Mumps
___ Cancer
___ Heart Disease
___ Goiter
___ Influenza

___ Arthritis
___ Epilepsy
___ Mental disorder
___ Lumbago
___ Eczema
___ Aids

___ Measles
___ Diabetes
___ Venereal infection
___ Alcoholism
___ Pleurisy
___ Anemia

Please enter '2' for Previously, '3' for Presently for each of the following signs and symptoms. Leave blank if it does not apply.

GENERAL SYMPTOMS

___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of sleep
___ Fatigue
___ Nervousness
___ Loss of weight
___ Allergy
___ Wheezing
___ Neuralgia
___ Numbness or pain in arms, legs, hands

GASTRO-INTESTINAL

___ Poor appetite
___ Poor digestion
___ Excessive hunger
___ Belching or gas
___ Nausea
___ Vomiting
___ Vomiting blood
___ Pain over stomach
___ Constipation
___ Diarrhea
___ Colon trouble
___ Hemorrhoids (piles)
___ Liver trouble
___ Jaundice
___ Gall bladder trouble

EYE/EAR/NOSE/THROAT

___ Poor vision
___ Crossed eyes
___ Pain in eyes
___ Deafness
___ Earache
___ Ear noises
___ Ear discharges
___ Nasal obstruction
___ Nose bleeds
___ Sore throats
___ Hoarseness
___ Hay fever
___ Asthma
___ Frequent colds
___ Enlarged thyroid
___ Tonsillitis
___ Sinus trouble
___ Trouble swallowing

MUSCLES & JOINTS

___ Weakness
___ Twitching
___ Stiff neck
___ Backache
___ Swollen joints
___ Tremors
___ Foot trouble
___ Painful tail bone
___ Pain between shoulders
___ Hernia
___ Spinal curvature

CARDIO-VASCULAR

___ Rapid heart
___ Slow heart
___ High blood pressure
___ Low blood pressure
___ Pain over heart
___ Previous heart trouble
___ Swelling ankles
___ Poor circulation
___ Varicose veins
___ Strokes

SKIN OR ALLERGIES

___ Skin eruptions
___ Itching
___ Bruising easily
___ Dryness
___ Boils
___ Sensitive skin
___ Hives or allergy
___ Eczema

RESPIRATORY

___ Chronic cough
___ Spitting blood
___ Spitting phlegm
___ Chest pain
___ Difficulty breathing

GENITO-URINARY

___ Frequent urination
___ Painful urination
___ Blood in urine
___ Kidney infection
___ Bed wetting
___ Inability to control urine
___ Prostate trouble
__________ Date of last prostate exam

WOMEN ONLY

___ Painful periods
___ Excessive flow
___ Irregular cycles
___ Hot flashes
___ Cramps or backache
___ Miscarriage
___ Vaginal discharge
___ Pregnant at this time
___________ Last pap date
___________ Breast exam

Patient's signature ____ Date ______________________