Patient Case History

PATIENT

NAME ______________________ SS# ______________________

ADDRESS ______________________ REFERRED BY ______________________

CITY ______________________ STATE __________ ZIP __________

PHONE # ______________________ SEX ❑ M ❑ F BIRTH DATE __________

TYPE OF BUSINESS ______________________ OCCUPATION ______________________

EMPLOYER ______________________ PHONE # ______________________

ADDRESS ______________________ E-MAIL ______________________

CITY ______________________ STATE __________ ZIP __________

SPOUSE

NAME ______________________ SS# ______________________

ADDRESS ______________________ BIRTH DATE ______________________

CITY ______________________ STATE ______ ZIP __________

EMPLOYER ______________________ EMPLOYER PHONE # ______________________

PAST MEDICAL HISTORY

HAVE YOU EVER HAD BEFORE OR BEEN TREATED FOR:

❑ A SURGERY	❑ A CAR ACCIDENT	❑ A FALL	❑ A FRACTURE
❑ A JOB INJURY	❑ A SPORTS INJURY	❑ DIABETES	❑ ARTHRITIS
❑ DIZZINESS	❑ STOMACH PROBLEMS	❑ HEART TROUBLE	❑ TUBERCULOSIS
❑ NUMBNESS	❑ LUNG PROBLEMS	❑ NERVOUSNESS	❑ BACKACHES
❑ ANEMIA	❑ SINUS TROUBLE	❑ KIDNEY TROUBLE	❑ HEADACHES
❑ NECK PAIN	❑ RHEUMATIC FEVER	❑ HOSPITALIZATION	❑ CANCER
❑ ALLERGIES	❑ FREQUENT COLDS	❑ BED-WETTING	❑ TREMORS
❑ DEPRESSION	❑ PAINFUL JOINTS	❑ SWOLLEN JOINTS	❑ STRESS
❑ STROKE	❑ JAW PAIN OR CLICK	❑ EATING DISORDERS	❑ ASTHMA
❑ FAINTING	❑ PAINFUL COUGH	❑ RINGING IN EARS	❑ EPILEPSY
❑ DISC HERNIAS	❑ VENEREAL DISEASE	❑ BREAST LUMPS	❑ HEPATITIS
❑ VISION	❑ HIGH BLOOD PRESSURE	❑ FOOT TROUBLE	❑ ULCERS
❑ SCOLIOSIS	❑ SLEEPING PROBLEMS	❑ INGUINAL HERNIA	❑ AIDS/ARC

DESCRIBE CHECKED ITEMS INCLUDING DOCTOR'S NAMES, DATES AND REMAINING EFFECTS. IF ANY, EXPLAIN: ______________________

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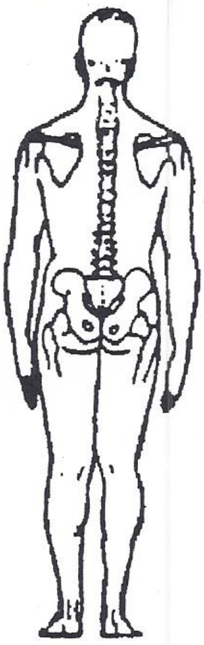
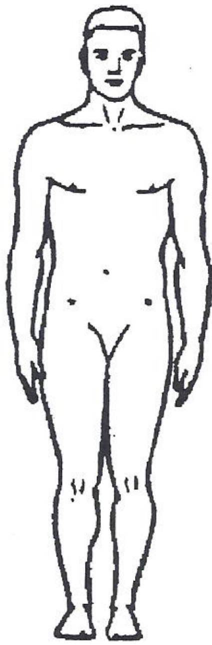
CURRENT SYMPTOMS / PROBLEM





PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON DRAWINGS TO THE LEFT.

LIST BELOW THE MAJOR SYMPTOMS YOU ARE FEELING NOW:

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ARE YOUR SYMPTOMS DUE TO:
❑ CAR ACCIDENT ❑ WORK INJURY ❑ SPORTS INJURY ❑ HOME INJURY ❑ FALL
❑ SLIP ❑ NO APPARENT REASON, JUST STARTED ❑ PREGNANCY

PAINS ARE:
❑ SHARP ❑ DULL ❑ CONSTANT ❑ INTERMITTENT ❑ GETTING WORSE ❑ STAYING SAME

IS THE PROBLEM INTERFERING WITH: ❑ WORK ❑ SLEEP ❑ HOME LIFE ❑ RECREATION

DESCRIBE HOW YOUR PROBLEM STARTED ______________________________
____
____

DATE FIRST NOTICED SYMPTOMS: ______________ APPROXIMATE TIME: ______________

WHERE: ______________________________

OTHER SYMPTOMS YOU MIGHT BE EXPERIENCING SINCE THE ONSET OF YOUR PROBLEM:

❑ HEADACHES	❑ LIGHT BOTHERS EYES	❑ LOSS OF FEELING	❑ LOSS OF WEIGHT
❑ DIZZINESS	❑ LOSS OF BALANCE	❑ RINGING IN EARS	❑ IRRITABILITY
❑ DIARRHEA	❑ COLD HANDS	❑ HEART TROUBLE	❑ MEMORY LOSS
❑ FAINTING	❑ STOMACH PROBLEMS	❑ CHEST PAIN	❑ FATIGUE
❑ NUMBNESS	❑ LUNG PROBLEMS	❑ NERVOUSNESS	❑ COLD FEET
❑ PINS&NEEDLES	❑ SINUS TROUBLE	❑ LOSS OF TASTE	❑ FACE FLUSHED
❑ CONSTIPATION	❑ SHORTNESS OF BREATH	❑ LOSS OF SMELL	❑ DEPRESSION
❑ TENSION	❑ FREQUENT URINATION	❑ LIGHT HEADED	❑ SLEEPING

IF YOU ARE FEMALE, ARE YOU POSSIBLY PREGNANT ❑ YES ❑ NO

I UNDERSTAND THAT ALL FEES FOR PROFESSIONAL SERVICES RENDERED WILL BE PAYABLE ON THE SAME DAY SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

PATIENT'S SIGNATURE ______________________________ DATE: ______________

Family Health History

CONDITION	Father Age	Mother Age	Spouse Age	Brother Age	Brother Age	Sister Age	Sister Age	Child Age	Child Age	Child Age	Child Age
Allergies/asthma	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Arthritis	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Back Problems	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Cancer	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Digestion Problems	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Dizziness	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Headaches	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
High Blood Pressure	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Heart Trouble	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Neck Pain	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Numbness	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Ringing in Ears	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Shoulder Pain	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Sleeping Problems	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Stomach Problems	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
Other:	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P
	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P	C P

C=Current Health Problem P=Past Health Problem

If any of the above family members are deceased, please list their age at death and cause:

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