CASE HISTORY RECORD

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone #: _____

Age: _____ Date of Birth: _____ Email: _____

Sex: M F Marital Status: M S D W Number of Children: _____ Occupation: _____

Do you have MEDICARE? YES NO Do you use MEDICAID? YES NO

MEDICARE #: _____ MEDICAID #: _____ (If applicable)

Who referred you to our office? _____

_____

What is your chief complaint? _____

_____

_____

Are you having any other problems? If so, please describe them: _____

_____

_____

When did your chief complaint start? _____ Have you had this before? _____ When? _____

What do you believe caused it? _____

_____

Was this related to any injury at home? _____ Work? _____ Automobile?_____

If so, please give date and time of injury: _____

Have you ever had any other serious accidents or injuries? _____ If yes, please describe: _____

_____

_____

Have you ever had any surgery? _____ If yes, please list them: _____

_____

Have you ever had any broken bones? _____ If yes, please list them: _____

_____

Are you taking any medications for any conditions? _____ If yes, please list them: _____

_____

Have you consulted any other doctors for your current condition? _____ If so, what is the Doctors name?

_____

What treatment did you receive? _____

_____

HEALTH QUESTIONAIRE

This is a survey of the major systems of your body. Please check the blank beside any area that you have had problems with either presently or in the past.

MUSCULO-SKELETAL

____ Low Back Problems
____ Pain between shoulders
____ Neck problems
____ Arm problems
____ Leg problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Weak muscles
____ Hernias
____ Broken bones

NERVOUS SYSTEM

____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Seizures
____ Forgetfullness
____ Confusion
____ Depression
____ Mental Illness

CARDIOVASCULAR

____ Chest pain
____ Difficult breathing
____ Persistent cough
____ Blood pressure problems
____ Heart problems
____ Lung problems
____ Vascular disease

GENITO-URINARY

____ Bladder trouble
____ Kidney trouble
____ Uterus problems
____ Ovary problems
____ Prostate problems

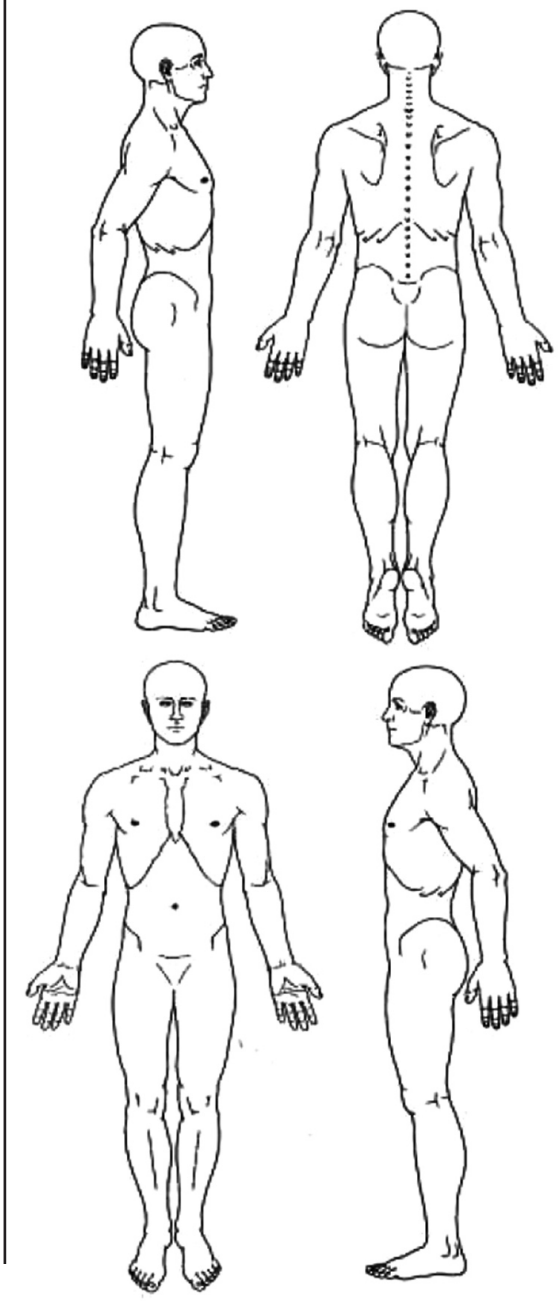
GASTRO-INTESTINAL

____ Poor appetite
____ Excessive hunger
____ Difficult chewing
____ Difficult swallowing
____ Excessive thirst
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder trouble
____ Weight trouble

EYE, EAR, NOSE AND THROAT

____ Vision problems
____ Eye disease
____ Ear pain
____ Ear noises
____ Hearing loss
____ Nose pain
____ Nose obstruction
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

MARK AREAS OF PAIN



Patient's Signature: _____