

Patient Case History

	NAME _____	SS# _____
P A T I E N T	ADDRESS _____	REFERRED BY _____
	CITY _____	STATE _____ ZIP _____
	PHONE # _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F BIRTH DATE _____
	TYPE OF BUSINESS _____	OCCUPATION _____
	EMPLOYER _____	PHONE # _____
	ADDRESS _____	E-MAIL _____
	CITY _____	STATE _____ ZIP _____

	NAME _____	SS# _____
S P O U S E	ADDRESS _____	BIRTH DATE _____
	CITY _____	STATE _____ ZIP _____
	EMPLOYER _____	EMPLOYER PHONE # _____

	HAVE YOU EVER HAD BEFORE OR BEEN TREATED FOR:			
P A S T M E D I C A L H I S T O R Y	<input type="checkbox"/> A SURGERY	<input type="checkbox"/> A CAR ACCIDENT	<input type="checkbox"/> A FALL	<input type="checkbox"/> A FRACTURE
	<input type="checkbox"/> A JOB INJURY	<input type="checkbox"/> A SPORTS INJURY	<input type="checkbox"/> DIABETES	<input type="checkbox"/> ARTHRITIS
	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> STOMACH PROBLEMS	<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> TUBERCULOSIS
	<input type="checkbox"/> NUMBNESS	<input type="checkbox"/> LUNG PROBLEMS	<input type="checkbox"/> NERVOUSNESS	<input type="checkbox"/> BACKACHES
	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> SINUS TROUBLE	<input type="checkbox"/> KIDNEY TROUBLE	<input type="checkbox"/> HEADACHES
	<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> HOSPITALIZATION	<input type="checkbox"/> CANCER
	<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> FREQUENT COLDS	<input type="checkbox"/> BED-WETTING	<input type="checkbox"/> TREMORS
	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> PAINFUL JOINTS	<input type="checkbox"/> SWOLLEN JOINTS	<input type="checkbox"/> STRESS
	<input type="checkbox"/> STROKE	<input type="checkbox"/> JAW PAIN OR CLICK	<input type="checkbox"/> EATING DISORDERS	<input type="checkbox"/> ASTHMA
	<input type="checkbox"/> FAINTING	<input type="checkbox"/> PAINFUL COUGH	<input type="checkbox"/> RINGING IN EARS	<input type="checkbox"/> EPILEPSY
	<input type="checkbox"/> DISC HERNIAS	<input type="checkbox"/> VENEREAL DISEASE	<input type="checkbox"/> BREAST LUMPS	<input type="checkbox"/> HEPATITIS
	<input type="checkbox"/> VISION	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> FOOT TROUBLE	<input type="checkbox"/> ULCERS
	<input type="checkbox"/> SCOLIOSIS	<input type="checkbox"/> SLEEPING PROBLEMS	<input type="checkbox"/> INGUINAL HERNIA	<input type="checkbox"/> AIDS/ARC
	DESCRIBE CHECKED ITEMS INCLUDING DOCTOR'S NAMES, DATES AND REMAINING EFFECTS. IF ANY, EXPLAIN: _____			

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PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON DRAWINGS TO THE LEFT.
LIST BELOW THE MAJOR SYMPTOMS YOU ARE FEELING NOW:

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: _____ AM PM

WHERE WERE YOU: AT WORK AT HOME AT RECREATION PLAYING A SPORT
 SLEEPING OTHER ACTIVITY: _____

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

- | | | | |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> LIGHT BOTHERS EYES | <input type="checkbox"/> LOSS OF FEELING | <input type="checkbox"/> LOSS OF WEIGHT |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> IRRITABILITY |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> COLD HANDS | <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> MEMORY LOSS |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> STOMACH PROBLEMS | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> FATIGUE |
| <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> LUNG PROBLEMS | <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> COLD FEET |
| <input type="checkbox"/> PINS&NEEDLES | <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> LOSS OF TASTE | <input type="checkbox"/> FACE FLUSHED |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> LOSS OF SMELL | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> TENSION | <input type="checkbox"/> FREQUENT URINATION | <input type="checkbox"/> LIGHT HEADED | <input type="checkbox"/> 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 _____