

Confidential Case History

Date: _____

Name: _____

DOB: _____

Sex: Female

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Occupation: _____

SSN: _____

Marital Status: Married

Spouse's Name: _____

Reason For Visit: _____

Date of Injury: _____

What are your primary complaints? _____

Do you have any other complaints? _____

When did your complaints begin? _____ Are you: Better Worse The Same

How did your complaints begin? _____

What makes you feel better? _____

What makes you feel worse? _____

Describe the pain: "sharp," "dull," "aching," "burning," "throbbing," "other: _____

Is this condition interfering with your: "Work," "Sleep," "Daily Routine," Other _____

Other doctors or therapists who have treated you for THIS condition: _____

List the details of any similar complaints in the past: _____

List surgical operations and years: _____

List the details of any past history of fracture, injury, illness, accidents, or medical treatment: _____

Family Physician: _____

(ROS) Please check any of the following that apply to you:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Bloating | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin Discoloration | <input type="checkbox"/> Belching | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold legs/arms | <input type="checkbox"/> Irritable Bowels | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Visual Difficulty | <input type="checkbox"/> Coughing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Food Intolerance | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Numbness | <input type="checkbox"/> Adrenal Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Urinary Urgency | <input type="checkbox"/> Tingling Limbs | <input type="checkbox"/> Swollen Nodes |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Burning Limbs | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Strain to Urinate | <input type="checkbox"/> Balance Problem | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Urinary Burning | <input type="checkbox"/> Memory Problem | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Skin Hair Changes | <input type="checkbox"/> Cloudy Urine | <input type="checkbox"/> Weakness | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Mole Changes | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Dropping Things | <input type="checkbox"/> Asthma |

Name:

DOB:

Date:

Family History

	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Mom' Mom	_____	_____	_____	_____	_____
Mom' Dad	_____	_____	_____	_____	_____
Dad's Mom	_____	_____	_____	_____	_____
Dad's Dad	_____	_____	_____	_____	_____

Describe your job duties: _____

How much do you smoke? _____

How much alcohol do you drink per week? _____

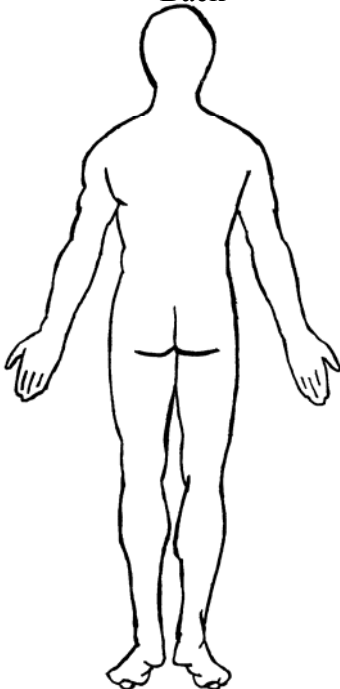
How much exercise do you get a week? _____

How much water do you drink each day? _____

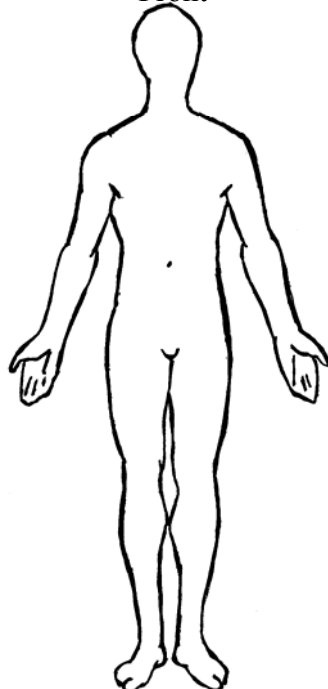
How much coffee do you drink a day? _____

How much soda do you drink a day? _____

Back



Front



Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

- • • Aching
- = = = Numbness
- OOO Pins & Needles
- x x x Burning
- ///// Stabbing
- ++++ Other

Is there anything else you think we need to know? _____
