

Patient Case History

NAME _____ ADDRESS _____ CITY _____ HM.PHONE # () _____ TYPE OF BUSINESS _____ EMPLOYER _____ ADDRESS _____ CITY _____ E-MAIL _____	SS# _____ REFERRED BY _____ STATE _____ ZIP _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F BIRTH DATE ___/___/___ OCCUPATION _____ WK.PHONE # () _____ STATE _____ ZIP _____ CELL PHONE () _____
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NAME _____ ADDRESS _____ CITY _____ EMPLOYER _____ WK. PHONE # () _____	SS# _____ BIRTH DATE _____ STATE _____ ZIP _____ CELL NUMBER () _____
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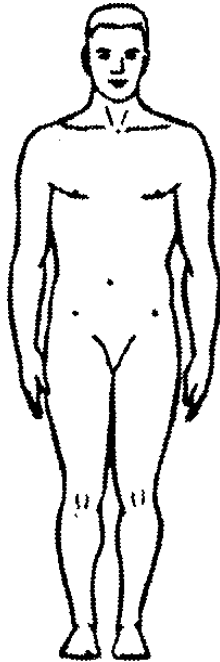
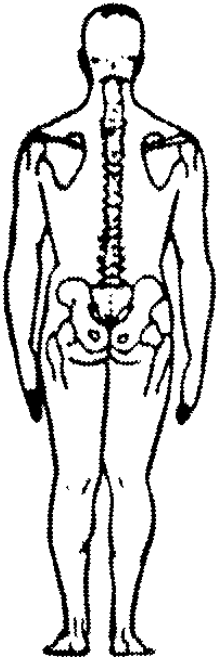
HAVE YOU EVER HAD BEFORE OR BEEN TREATED FOR:

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
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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 _____