CONFIDENTIAL PATIENT CASE HISTORY

Please complete this entire form. This confidential history will be part of your permanent record.

Name _____ Birthday _____ Sex □ M □ F

Address _____ City _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Work _____ Cell _____ E-Mail _____

Marital Status: □ M □ S □ D □ W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How did you hear about us? _____

What is your major complaint?

_____

_____

How long have you had this symptom?

_____

Have you had this or similar symptoms in the past?

_____

Do any positions make it feel worse?

_____

Do any positions make it feel better?

_____

Has this symptom: □ Improved □ Unchanged □ Getting Worse

Is this symptom interfering with your: □ Work □ Sleep □ Daily Routine □ Other _____

Has there been other doctors or therapist who have treated THIS condition

_____

What do you think caused this condition?

_____

List surgical operations and years:

_____

Do you have a family physician? Name: _____

Are you on any medications? dosage and frequency: _____

_____

Have you been in an auto accident or had any other personal injury? □ Yes □ No
If YES, describe: _____

_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

REVIEW OF SYSTEMS (Check only the ones you now have or have had in the past)

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐ Heavy ☐ Mod ☐ Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____
Last Prostate Exam _____

Name: _____

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

ENDOCRINE

Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION/VACCINATION

DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE

A +	☐	A -	☐
B +	☐	B -	☐
AB +	☐	AB -	☐
O +	☐	O -	☐

Other _____

BLOOD TRANSFUSIONS

Date_____

Date_____

Date_____

Date_____

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

Hay Fever	☐	Parasites	☐
Mumps	☐	Epilepsy	☐
Rheumatic Fever	☐	Paralysis	☐
Allergies	☐	Polio	☐
Angina	☐	Mental Illness	☐
Cancer	☐	Alcoholism	☐
Tumor	☐	Depression	☐
Blood Disease	☐	Nervous Breakdown	☐
Leukemia	☐	Migraine	☐
Heart Trouble	☐	Gout	☐
Varicose Veins	☐	Hemorrhoids	☐
Phlebitis	☐	Prostate Problems	☐
Hypertension	☐	Sexual Problems	☐
Stroke	☐	Gonorrhea	☐
Ulcers	☐	Syphilis	☐
Jaundice	☐	Diabetes	☐
Skin Trouble	☐	Bladder Trouble	☐
Gallstones	☐	Kidney Stones	☐
Liver Trouble	☐	Kidney Infections	☐
Hepatitis	☐	Dysentery	☐

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal

Last TB Skin Test _____ ☐ Normal ☐ Abnormal

Allergies: _____

_____

_____

_____

_____

Name: _____

FAMILY HISTORY (List any of the diseases listed above which run in your family)

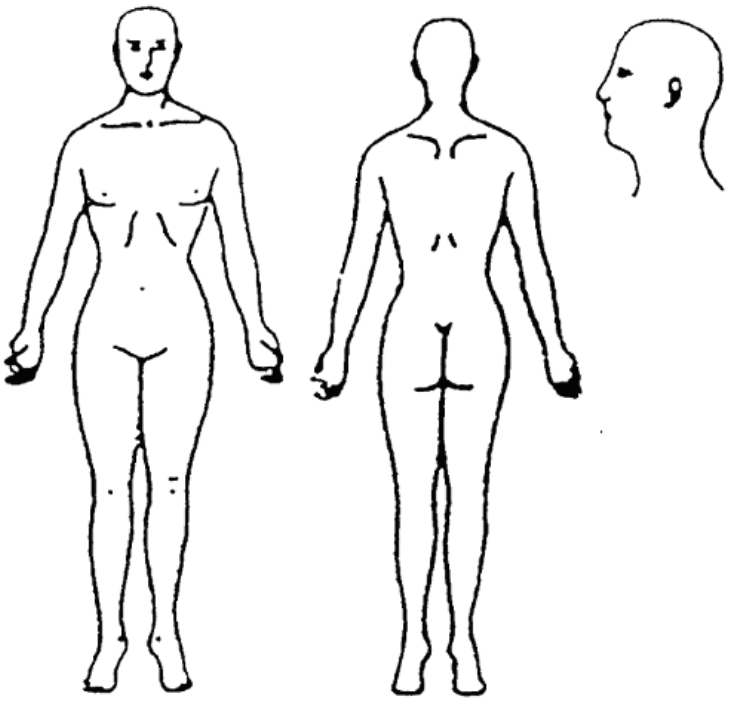
Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY (Check the boxes and fill in)

Current Weight _____
Have you recently lost or gained weight?_____
Mental Work □ Heavy □ Moderate □ Light Hours per day _____
Physical Work □ Heavy □ Moderate □ Light Hours per day _____
Exercise □ Heavy □ Moderate □ Light Hours per week _____ Type _____
Smoking □ Current □ Previous Packs/Day _____ # of years _____
Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ # of Years _____
Caffeine Cups/Day _____ # of Years _____
(Coffee, Tea, Cola)
Aspirin # per Day _____ # of Years _____ Others _____

Please fill out this form as accurately as possible. Mark the area(s) on the body diagram where you feel your described symptom(s). Use the appropriate symbol(s) to mark areas of the body. Include all affected areas.

Aches = **o** Numbness = ▲ Pins/Needles = □ Burning Sensation = **x** Stabbing Sensation = ↑



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None ——————————Severe

How bad have your symptoms been in the past?

None —————————— Severe

Name: _____