

CASE HISTORY

Last Name _____ First Name _____
Address _____ Apt # _____ City _____
State _____ Zip _____ Home Phone _____ Cell Phone _____
Social Security # _____ Driver License # _____
Sex (M) (F) Age _____ Birth Date ____/____/____ Email Address _____
Occupation _____ Employer _____ Work Phone _____
Employer's Address _____ City _____ State _____ Zip _____
Spouses Name: _____ Referred by _____

What is your major complaint? _____

Other Complaints or Health Conditions _____
How long have you had this condition? _____
Have you had this or similar conditions in the past? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? Yes ___ No ___ Constant ___ Comes and goes ___
Is this condition interfering with your Work ___ Sleep ___ Daily Routine ___ Other ___
How long has it been since you really felt good? _____
List surgical operations: _____
Are you taking any medications? _____ If so, what kind? _____
Any non-prescription drugs? _____ If so, what kind? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS

Doctor (s) Name _____
Medical Doctors' Name _____ Address _____ Phone _____

Diagnosis _____ X-ray _____
Urinalysis _____ Blood Tests _____ Other tests _____
Treatment: Medication _____ Physiotherapy _____
Results of Treatment _____ Length of care _____
Were you off work/school? _____ If so, how long? _____
Have you returned to your same job? _____ If not, why _____

ACCOUNT/ INSURANCE INFORMATION: Person Responsible for this Account _____

Do you have any health insurance? Yes No Name of Insurance Company _____

If you do have Health Insurance, please provide your insurance card to us for verification.

Are you covered by Medicare? Yes No Medicare # _____ State Insurance Aid? Yes No

Is your condition due to an:

Accident? Yes No
If yes, was it related to an accident at work or in an automobile? _____

An Illness? Yes No
If yes, please explain _____
Other _____

Location of Accident _____ Date _____ Time _____ Injury reported to employer? Yes No
Name of supervisor _____
Description of accident _____
Were you injured? _____ Were you unconscious? _____ Any Fractures? _____
Cuts? _____ Abrasions? _____ Bruises? _____
Patient taken to _____ Hospital for _____ Confined to hospital for _____ Days _____ Hours
Name of hospital doctor _____
Have you had any other personal injury or accident? Past year ___ Past 5 years ___ Over 5 years ___ None ___

I understand that I am personally responsible and agree to the charges rendered for all services. I understand that if I suspend or terminate my care and treatment, any fees that are due will be immediately paid. I authorize payment of medical benefits to be made directly to the physician provider for services rendered. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information to this claim and the expenses reported.

Patient/Guardians Signature Date

Eyes, Ears, Nose and

Throat

- Sinus Problems
 - Allergies
 - Head Colds
 - Fatigue
- Runny Nose
- Sore Throat

Heart

- Irregular Heartbeat
- Heart Conditions
- High Blood Pressure

Lungs

- Cough
- Asthma
- Congestion
- Difficulty Breathing
 - Bronchitis
 - Pneumonia

Liver

- Gallbladder Conditions
 - Liver Conditions
 - Jaundice

Stomach

- Stomach Problems
- Nervous Stomach
 - Nausea
 - Acid Reflux
 - Heartburn
 - Indigestion
 - Ulcers

Pancreas

- Diabetes
- Pancreatitis
- Cystic Fibrosis

Intestines

- Irritable Bowel

Kidneys, Bladder

- Kidney Problems
- Bladder Problems

Colon

- Hemorrhoids
- Constipation
- Diarrhea
- Gas

Reproductive Organs

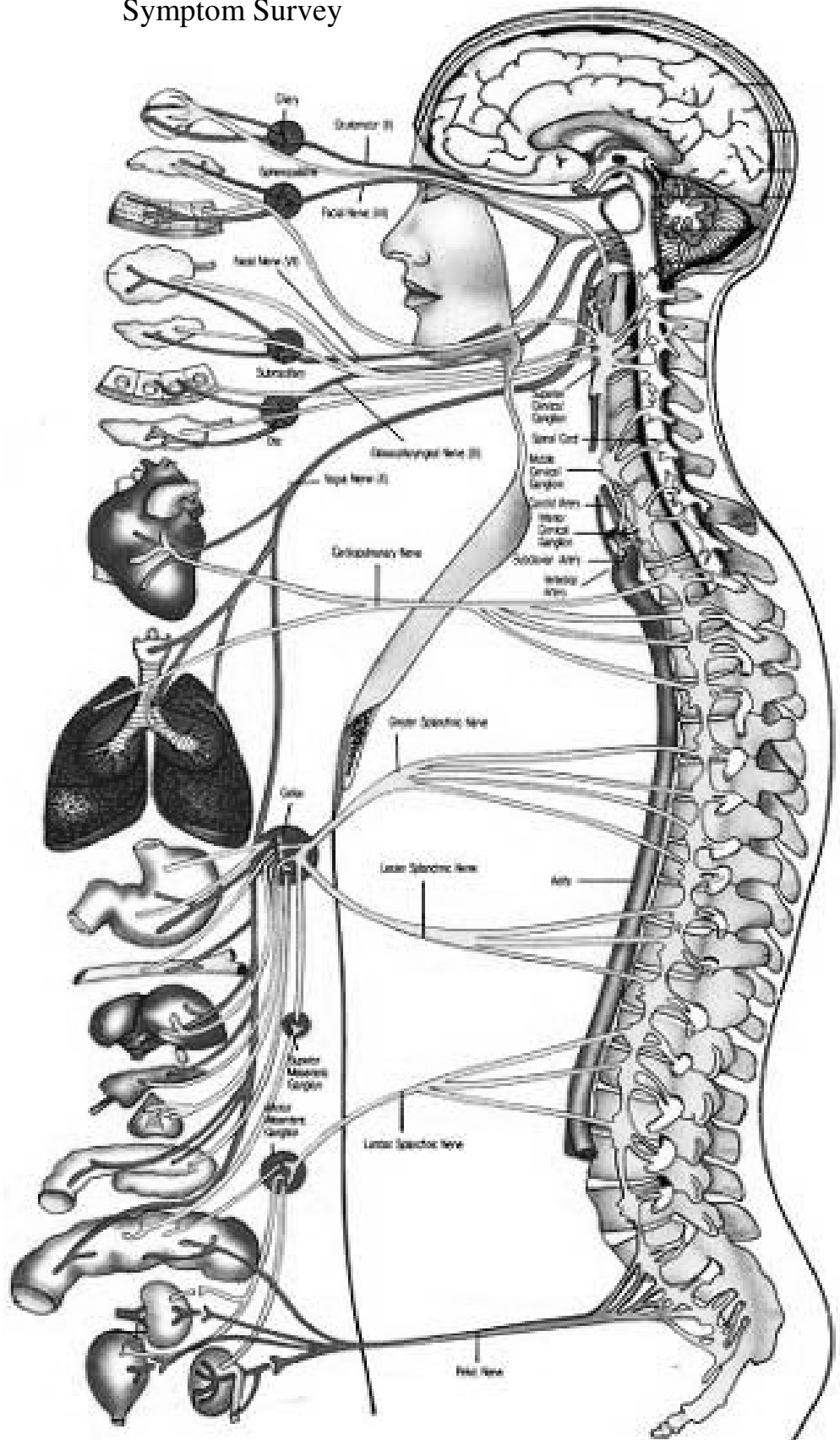
Male

- Erectile Dysfunction

Female

- Fibroid Cysts
- Endometriosis
- Menstrual Problems

Symptom Survey



Cancer-Type? _____ Name: _____ M or F

Other Health Issues:

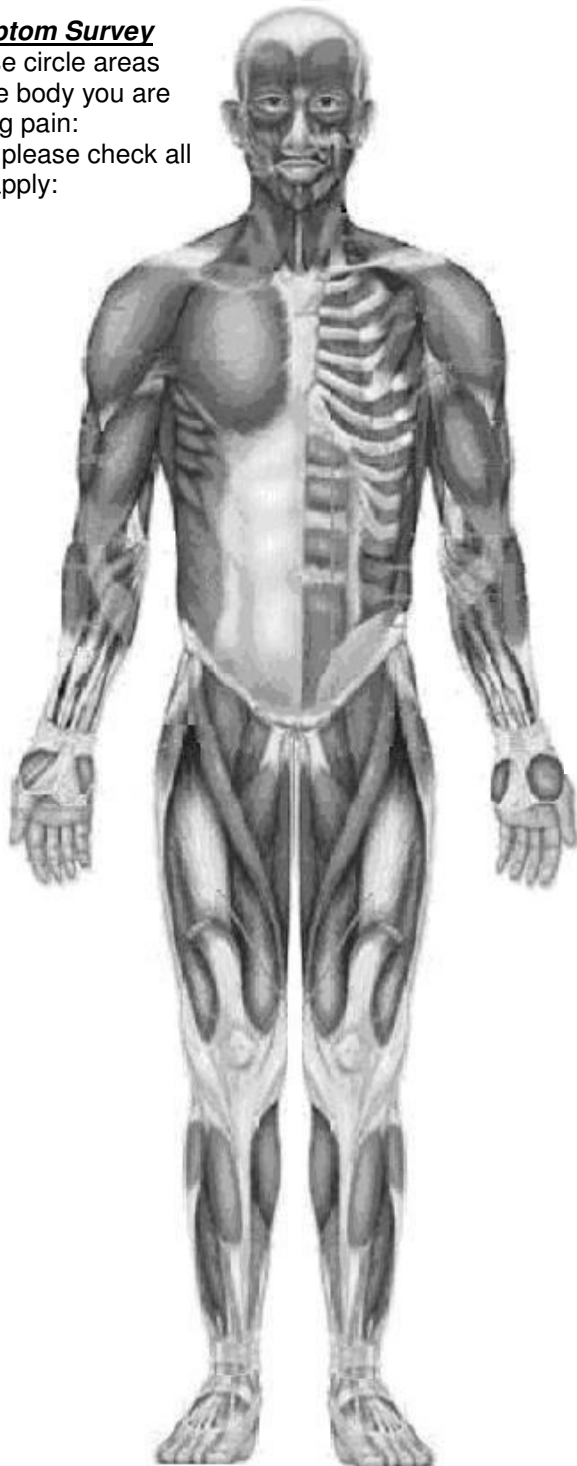
Signature: _____

Date: _____

Symptom Survey

Please circle areas on the body you are having pain:

Also, please check all that apply:



HEAD

- Headaches
- Dizziness/Lightheaded
- Blurred Vision
- Memory Difficulty
- Depression
- Mood Swings
- Buzzing/Ringing in ears
- High Blood Pressure
- Difficultly Sleeping
- Get sick easily/frequently
- Allergies

SHOULDERS

- Pain in joint
 - Right
 - Left
- Cant raise arm
 - Above shoulder
 - Over head
- Pinched nerve
- Muscle spasms
- Pain across shoulders

CHEST

- Pain
 - Sharp
 - Dull
- Shortness of Breath

LOW BACK

- Pain
 - Sharp
 - Dull
 - Constant
 - Comes and goes
- Muscle Spasms
- Relieved when _____

NECK

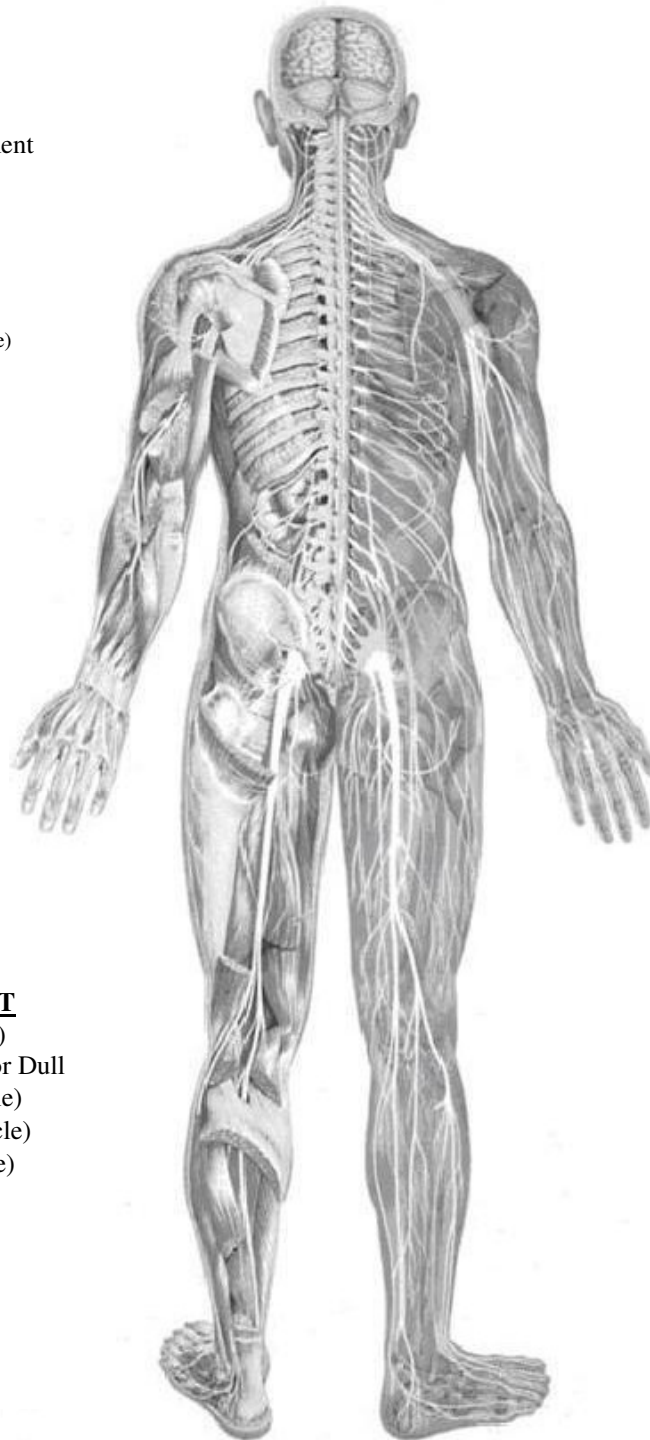
- Pain
 - Sharp
 - Dull
- Aggravated by movement
- Muscle Spasms
- Grinding Sounds
- Popping Sounds

ARMS AND HANDS

- Upper arm-R or L(circle)
- Elbow-R or L(circle)
- Movement aggravated
- Forearm-R or L(circle)
- Wrist-R or L(circle)
- Hands-R or L(circle)
- Fingers
- Numbness in arms
- Numbness in fingers
- Loss of grip strength

MID BACK

- Pain
 - Sharp
 - Dull
- Dull ache
- Muscle spasms
- From front to back



HIPS, LEGS AND FEET

- Hip Pain-R or L(circle)
 - Sharp or Dull
- Knee Pain-R or L(circle)
- Ankle Pain-R or L(circle)
- Foot Pain-R of L(circle)
- Leg cramps
- Cramps in feet
- Numbness of leg
- Numness of toes
- Feet feel cold
- Swollen ankles
- Swollen feet

Name: _____ M OR F
Signature: _____ Date: _____

Remarks: _____