

# CASE HISTORY

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ E-Mail \_\_\_\_\_  
Driver Lic. # \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: Male Female  
Marital Status: Married Single Widowed Divorced Number of Children \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Person responsible for this account \_\_\_\_\_ Referred by \_\_\_\_\_  
What is your major complaint? \_\_\_\_\_  
\_\_\_\_\_

Other complaints: \_\_\_\_\_  
\_\_\_\_\_

What caused your condition? \_\_\_\_\_

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  COME AND GOES

Is this condition interfering with your: WORK  SLEEP  DAILY ROUTINE   OTHER \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_ What kind & strength? \_\_\_\_\_  
\_\_\_\_\_

Any non-prescription drugs? \_\_\_\_\_ What kind? \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Date Last Seen \_\_\_\_\_

**OTHER DOCTORS SEEN FOR THIS CONDITION:** MD  DC  DO  DDS

Doctor's Name \_\_\_\_\_ Dates Treated \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Dates Treated \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Dates Treated \_\_\_\_\_

Diagnosis \_\_\_\_\_

X-rays & Dates \_\_\_\_\_ Medication \_\_\_\_\_

MRI(date & body region) \_\_\_\_\_

Physical Therapy Dates \_\_\_\_\_

Treatment Results \_\_\_\_\_ Length of time under care \_\_\_\_\_

Other Tests & Dates \_\_\_\_\_  
\_\_\_\_\_

## ACCIDENT INFORMATION:

Is your condition due to an accident?  Illness  OTHER \_\_\_\_\_

Did your accident occur while at work? YES  NO  Were you involved in an automobile accident? YES  NO

Date \_\_\_\_\_ Time \_\_\_\_\_ Injury reported to employer YES  NO  Name of Supervisor \_\_\_\_\_

I clearly understand and agree that all services rendered to me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered to me will be immediately due & payable.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



REVIEW OF SYSTEMS – Check only the ones you now **have** or have **had** in the past.

<u>General</u>	<u>Now</u>	<u>Past</u>	<u>Breasts</u>	<u>Now</u>	<u>Past</u>	<u>Genitourinary</u>	<u>Now</u>	<u>Past</u>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Urine Color _____		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Spotting b/Periods	<input type="checkbox"/>	<input type="checkbox"/>
<u>Skin</u>	<u>Now</u>	<u>Past</u>	<u>Lungs</u>	<u>Now</u>	<u>Past</u>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type _____		
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Age at First Period _____		
<u>Head</u>	<u>Now</u>	<u>Past</u>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Cycle _____		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow _____		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<u>Heart</u>	<u>Now</u>	<u>Past</u>	No. of Pregnancies _____		
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages _____		
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions _____		
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow <input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light		
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Last Period _____		
<u>Ears</u>	<u>Now</u>	<u>Past</u>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Last Pap Smear _____		
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Last Vaginal Exam _____		
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Last Mammogram _____		
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Last Prostate Exam _____		
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<u>Neurologic</u>	<u>Now</u>	<u>Past</u>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<u>Blood</u>	<u>Now</u>	<u>Past</u>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>
<u>Nose</u>	<u>Now</u>	<u>Past</u>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Facial	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<u>Gastrointestinal</u>	<u>Now</u>	<u>Past</u>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrine</u>	<u>Now</u>	<u>Past</u>
<u>Mouth</u>	<u>Now</u>	<u>Past</u>	Belching	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<u>Psychiatric</u>	<u>Now</u>	<u>Past</u>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Hyperventillation	<input type="checkbox"/>	<input type="checkbox"/>
<u>Throat</u>	<u>Now</u>	<u>Past</u>	Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Insecurity	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>	Troubled Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<u>Genitourinary</u>	<u>Now</u>	<u>Past</u>	Irritable	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>	Undecidedness	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Timid	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neck</u>	<u>Now</u>	<u>Past</u>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
Masses	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

<b>Musculoskeletal</b>	<b>Now</b>	<b>Past</b>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Twitching	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>

**Immunization/Vaccinations**

DPT	<input type="checkbox"/>
Mumps	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>
Measles	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>
Influenza	<input type="checkbox"/>
Polio	<input type="checkbox"/>
MMR	<input type="checkbox"/>

**Blood Type**

A+	<input type="checkbox"/>	A-	<input type="checkbox"/>
B+	<input type="checkbox"/>	B-	<input type="checkbox"/>
AB+	<input type="checkbox"/>	AB-	<input type="checkbox"/>
O+	<input type="checkbox"/>	O-	<input type="checkbox"/>

**Surgeries**

Date _____	Type _____
Date _____	Type _____
Date _____	Type _____
Date _____	Type _____

**Social History**

Current Weight \_\_\_\_\_  
 Have you recently gained \_\_\_\_\_ or lost \_\_\_\_\_ weight? How much? \_\_\_\_\_

**Mental Work**

Heavy  Mod  Light  
 Hours Per Day \_\_\_\_\_

**Physical Work**

Heavy  Mod  Light  
 Hours Per Day \_\_\_\_\_

**Exercise**

Heavy  Mod  Light  
 Hours Per Week \_\_\_\_\_  
 Type of Exercise \_\_\_\_\_

**Smoking**

Current  Previous  
 Packs Per Day \_\_\_\_\_  
 Smoked for how long? \_\_\_\_\_

**Caffeine**

Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Soda \_\_\_\_\_  
 Cups/Day \_\_\_\_\_ No. of Years \_\_\_\_\_

**Alcohol**

Beer/week \_\_\_\_\_ Wine/week \_\_\_\_\_  
 Liquor/week \_\_\_\_\_ No. of Years \_\_\_\_\_

**Aspirin**

No./Day \_\_\_\_\_ No. of Years \_\_\_\_\_

**Family History**

Check any of the diseases that have occurred within your family.  
 Heart Disease  Heart Attack  
 Stroke  Emphysema  
 Diabetes  Cancer

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

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

Date of Last Chest X-Ray \_\_\_\_\_  Normal  Abnormal  
 Last TB Skin Test \_\_\_\_\_  Normal  Abnormal  
 Allergies: \_\_\_\_\_

Mark An "X" On The Lines:

How bad are your symptoms now? \_\_\_\_\_  
 Mild Moderate Severe  
 How bad have they been in the past? \_\_\_\_\_  
 Mild Moderate Severe

Mark The Areas Of Your Symptoms On The Figure Below:

Use the following symbols:

**Aches** ~~~~~ **Numbness** ooooo **Pins/Needles** ..... **Stabbing** /////  
 ~~~~~ ooooo ..... /////

