

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.
THANK YOU.

Name _____ Birthday _____ Sex M F

Address _____ City _____ Zip _____

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

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

Occupation _____ Employer _____

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

What is your major complaint?

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: Improved Unchanged Getting Worse

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

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 _____

Medications, dosage and frequency:

Have you been in an auto accident or had any other personal injury? Y N 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 N P
- Fatigue N P
- Fever N P
- Chills N P
- Night Sweats N P
- Fainting N P

SKIN

- Color Changes N P
- Nail Changes N P
- Hair Changes N P
- Moles N P
- Rashes N P
- Sores N P
- Weakness N P

HEAD

- Headaches N P
- Injuries N P
- Bumps N P
- Last Eye Exam _____
- Glasses N P
- Contacts N P
- Cataracts N P

EARS

- Hard of Hearing N P
- Deafness N P
- Ringing N P
- Discharge N P
- Earache N P
- Itching N P
- Dizziness N P
- Room Spins N P

NOSE

- Decreased Smell N P
- Bleeding N P
- Pain N P
- Discharge N P
- Obstruction N P
- Post Nasal Drip N P
- Deviated Septum N P
- Runny Nose N P
- Sinus Congestion N P

MOUTH

- Bleeding Gums N P
- Sores N P
- Dental Problems N P
- Bad Breath N P
- Loss of Taste N P
- Dry Mouth N P
- Ulcers N P
- Blisters N P

THROAT **NOW** **PAST**

- Soreness N P
- Bad Tonsils N P
- Hoarseness N P
- Pain N P
- Trouble Swallowing N P
- Recurrent Infections N P

NECK

- Neck Enlargement N P
- Stiff Neck N P
- Soreness N P
- Lumps N P
- Masses N P

BREASTS

- Discharge N P
- Lumps N P
- Pain N P
- Bleeding N P
- Nipple Changes N P
- Skin Changes N P
- Bloated N P

LUNGS

- Cough N P
- Phlegm N P
- Blood N P
- Short of Breath N P
- Wheezing N P
- Pain N P
- Congestion N P
- Inhalant Exposure N P

HEART

- Murmur N P
- Palpitations N P
- Rapid Heartbeat N P
- Swollen Extremities N P
- Cold Extremities N P
- Chest Pain/Pressure N P
- Varicose Veins N P
- Blood Clots N P
- Blue Extremities N P

BLOOD

- Anemia N P
- Low Blood Iron N P
- Easy Bruising N P
- Easy Bleeding N P
- Swollen Nodes N P
- Painful Nodes N P
- Sugar in Blood N P
- Red Spots N P

GASTROINTESTINAL **NOW** **PAST**

- Abdominal Pain N P
- Nausea N P
- Bloated N P
- Belching N P
- Heartburn N P
- Indigestion N P
- Irregular Bowel Habits N P
- Constipation N P
- Diarrhea N P
- Gas N P
- Hemorrhoids N P
- Poor Appetite N P
- Food Intolerance N P
- Bloody Stools N P
- Black Stools N P

GENITOURINARY

- Urgency N P
- Incontinence N P
- Straining N P
- Back Pain N P
- Frequent Voiding N P
- Stones N P
- Burning N P
- Bed Wetting N P
- Small Stream N P
- Discharge N P
- Impotence N P
- Dribbling N P
- Cloudy Urine N P
- Urine Color _____
- Spotting Between _____
- Periods N P
- Menstrual Cramps N P
- Discharge N P
- Itching N P
- Painful Intercourse N P
- Irregular Periods N P
- Hot Flashes N P
- 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 | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Vertigo | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Dizziness | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Hand Trembling | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Loss of Sensation | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Incoordination | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Loss of Facial | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Weak Grip | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Paralysis | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Difficulty Speech | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Tingling | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Loss of Memory | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Numbness | <input type="checkbox"/> N | <input type="checkbox"/> P |

ENDOCRINE

| | | |
|------------------|----------------------------|----------------------------|
| Weight Loss | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Weight Gain | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Extremely Thin | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Heat Intolerance | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Cold Intolerance | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Hair Changes | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Breast Changes | <input type="checkbox"/> N | <input type="checkbox"/> P |

IMMUNIZATION/VACCINATION

| | |
|--------------|----------------------------|
| DPT | Y <input type="checkbox"/> |
| Mumps | Y <input type="checkbox"/> |
| Smallpox | Y <input type="checkbox"/> |
| Typhoid | Y <input type="checkbox"/> |
| Tetanus | Y <input type="checkbox"/> |
| Measles | Y <input type="checkbox"/> |
| Pneumococcal | Y <input type="checkbox"/> |
| Influenza | Y <input type="checkbox"/> |
| Polio | Y <input type="checkbox"/> |
| MMR | Y <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"/> |
| Other | _____ | | |

BLOOD TRANSFUSIONS

Date _____

Date _____

Date _____

Date _____

| PSYCHIATRIC | NOW | PAST |
|--------------------|----------------------------|----------------------------|
| Hyperventilation | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Insecurity | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Depression | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Troubled Sleep | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Irritable | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Undecidedness | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Timid | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Hallucinations | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Loss of Memory | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Alcoholism | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Drug Addiction | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Drug Dependent | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Suicidal Thoughts | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Extreme Worry | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Sexual Problems | <input type="checkbox"/> N | <input type="checkbox"/> P |

| MUSCULOSKELETAL | NOW | PAST |
|------------------------|----------------------------|----------------------------|
| Muscle Pain | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Muscle Weakness | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Muscle Cramps | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Muscle Twitching | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Joint Stiffness | <input type="checkbox"/> N | <input type="checkbox"/> P |
| Joint Pain | <input type="checkbox"/> N | <input type="checkbox"/> P |

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

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

Date of Last Chest X-Ray _____ Normal Abnormal

Last TB Skin Test _____ Normal Abnormal

Allergies: _____

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 _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine (Coffee, Tea, Cola) Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles Stabbing ////

MARK AN "X" ON THE LINES:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe

