CONFIDENTIAL CASE HISTORY

Email _____
Home Phone _____
Name _____ **Work Phone** _____

Address_____ **City**_____ **State**_____ **Zip**_____

Date of Birth _____ **Age** _____ **M** ___ **F** ___ **Marital Status** _____ **No. of Children** _____
Occupation _____ **Referred by** _____

Please Print

1. PRESENT SYMPTOM: What is your major complaint?_____

_____

2. MINOR COMPLAINTS: Other areas of pain or concern? _____

_____

3. When did you first notice major complaint? _____

4. What brought it on? _____

5. What activities aggravate condition? _____

6. Is this condition getting progressively worse? Yes____ **No**____ **Constant**____ **Comes and goes**_____

7. Is this condition interfering with your… Work _____ **Sleep** _____ **Daily Routine** _____

8. What do you believe is wrong with you? _____

9. What have you done to get relief? _____

10. Has there been a medical diagnosis? _____ **If yes, what was the diagnosis?** _____
By whom? _____ _____
X-Rays _____ **Blood Work** _____

PAST HISTORY

11. Have you had a similar problem before? ____ **If yes, when?** _____ **What caused those episodes?** _____
_____
What relieved them? _____
Did they disable you? _____ **Prevent you from working?** _____ **Hospitalize you?** _____
What was the previous diagnosis? _____ **What were the treatments?** _____
_____ **Did they help?** _____
Name of attending physician? _____

Are you on any medications? ____ **Please list them** _____

Are you taking any of the following?

( )Laxatives ( )Sedatives
( )Aspirins / NSAIDS ( )Vitamins
( )Sleeping Pills ( )Minerals
( )Insulin ( )Herbs

Habits	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Weekly Sugar Consumption	_____	_____	_____	_____

Have you ever Yes No Describe briefly

- Had any operations? ____ ____ _____
_____
_____
_____
- Broken any bones? ____ ____ _____
_____
_____
- Been in an accident? ____ ____ _____
- If yes, did you receive a whiplash? _____

DO YOU HAVE ANY DIFICULTY WITH ANY OF THE FOLLOWING:

( )Headaches
( )Shooting head pains
( )Sinus trouble
( )Loss of smell
( )Hayfever
( )Asthma
( )Loss of taste
( )Tightness in throat
( )Inflammation of throat
( )Thyroid trouble
( )Face flushed
( )Twitching of face
( )Loss Of memory
( )Fatique
( )Depression
( )Head feels too heavy
( )Dizziness
( )Fainting
( )Loss of balance
( )Ringing in ears
( )Wear glasses
( )Lights bother eyes
( )Muscle spasms in neck
( )Grating in neck
( )Tightness of shoulder muscles
( )Neuritis in shoulders and arms
( )Pins and needles in arms and hands
( )Cold hands
( )Chest pains
( )Shortness of breath
( )T.B.
( )Heart pain
( )Heart palpitations
( )Heart attacks
( )High blood pressure
( )Low blood pressure
( )Anemia
( )Rheumatic fever
( ) Nervous stomach
( )Stomach trouble
( )Ulcers
( )Nerves and nervousness
( )Inner tension
( )Irritability
( )Cold sweats
( )Liver trouble
( )Gall bladder trouble
( )Indigestion
( )Intestinal gas
( )Constipation
( )Kidney trouble
( )Bladder trouble
( )Diabetes
( )Cancer
( )Sleeping problems
( )Painful joints
( )Swollen joints
( )Arthritis
( )Slipped disc
( )Pinched nerves in back
( )Pins and needles in legs
( )Swollen ankles
( )Cold feet
( )Pains in legs and feet

How many bowel movements daily? _____ Do you have a history of constipation? _____

If yes, what have you done to relieve it? _____

Age of mattress? _____ Comfortable _____ Uncomfortable _____ Bedboard _____

Do you use a foam pillow? _____ Do you sleep on : Side _____ Back _____ Stomach _____

Are you wearing heel lifts? _____ Sole lifts? _____ Arch Supports _____ Inner Soles _____

Signature _____

Date _____