

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/State _____ 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? _____ Height _____

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

