E-mail Address _____

Cell Phone _____

CONFIDENTIAL PATIENT CASE HISTORY

Date _____

Name _____ Home Phone _____ S.S.# _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital Status M S W D Number of Children _____

Employer _____ Occupation _____

Address _____ Work Phone _____

Name of Spouse _____ Occupation _____

Spouse's Employer _____ Work Phone _____

In case of an emergency, please notify, _____ Phone Number _____

How did you hear about our office? ☐ Friend _____ ☐ Yellow Pages ☐ Radio ☐ TV ☐ Employer

☐ Other _____

Please list complaint and date the condition started, starting with your major complaints.

Complaints	*Date Started*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Have you seen other doctors for your condition? ☐ Yes ☐ No

Please list other doctors seen and approximate date seen.

Doctors	*Approximate Date Seen*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Have you experienced any serious accidents or falls within the ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

If you have experienced an accident, what type was it? ☐ Auto ☐ Work ☐ Home ☐ Leisure ☐ Sports ☐ Other

Briefly explain—

_____

_____

Are you presently taking medication? ☐ Yes ☐ No (If yes, indicate below.)

☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ Tranquilizers ☐ Birth Control Pills ☐ Aspirin

Other _____

_____

List surgical operations you have had and approximate date.

	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ **AIDS**
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ **HIV Positive**
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ **Hepatitis**
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping cough

CHECK THE FOLLOWING SYMPTOMS YOU HAVE HAD:

GENERAL
- ☐ Allergy
- ☐ Chills
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness/depression
- ☐ Neuralgia
- ☐ Numbness
- ☐ Sweats
- ☐ Tremors

CARDIO-VASCULAR
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Hernia
- ☐ Low back pain
- ☐ Lumbago
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders

Pain or numbness in:
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

- ☐ Painful tail bone
- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal curvature
- ☐ Swollen joints

EYES, EARS, NOSE & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Crossed eyes
- ☐ Deafness
- ☐ Dental decay
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far sightedness
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Near sightedness
- ☐ Nosebleeds
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

GASTRO-INTESTINAL
- ☐ Belching or gas
- ☐ Colitis
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Distension of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

SKIN
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Inability to control kidneys
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Pus in urine

FOR WOMEN ONLY
- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge

HAVE YOU EVER:	YES	NO
Been knocked unconscious?	☐	☐
Used a cane, crutch, or other support?	☐	☐
Been treated for a spine or nerve disorder?	☐	☐
Had a fractured bone?	☐	☐
Been hospitalized for other than surgery?	☐	☐
DO YOU:		
Now take vitamins or minerals?	☐	☐
Think you may need vitamins or minerals?	☐	☐
Have an allergy to any drug?	☐	☐

DESCRIBE BRIEFLY

_____

_____

_____

_____

_____

_____

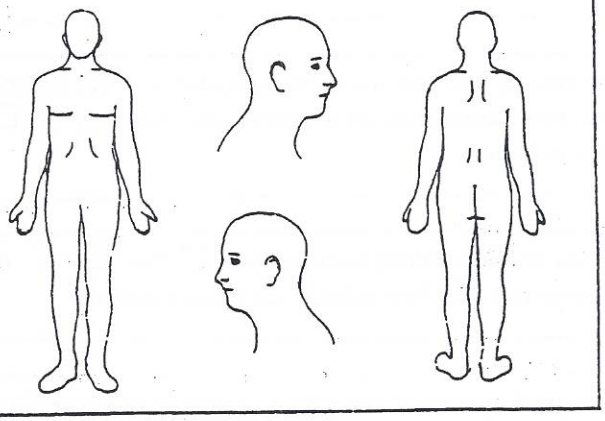
_____

_____

DATE OF LAST:	Less than 6 months	6–18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Please mark your areas of pain on the figures below.



ARE YOU PREGNANT? ☐ YES ☐ NO

PLEASE CHECK THE TYPE OF CARE YOU DESIRE SO THAT WE MAY BE GUIDED BY YOUR WISHES WHEN POSSIBLE.

☐ I PREFER THE DOCTOR TO SELECT THE TYPE OF CARE HE FEELS IS BEST FOR ME

☐ MAXIMUM IMPROVEMENT

☐ TEMPORARY RELIEF

ARE YOU INSURED ? ☐ **YES** ☐ **NO** **COMPANY** _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONNALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE. I FURTHER AGREE IN CASE OF MY DEFAULTING ON THIS ACCOUNT THAT I WILL BE SOLELY RESPONSIBLE FOR ALL COSTS OF COLLECTION, ATTORNEY FEES, AND/OR COURT COSTS, NECESSARY TO RECOVER THIS ACCOUNT.

Patient's Signature _____ **Date** _____

Guardian or Spouse's Signature Authorizing Care _____ **Date** _____

Information taken by: