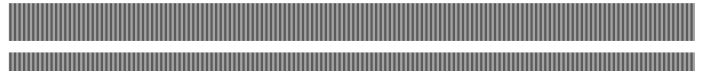


C

ase History



Name _____ Date _____ S.S. # _____

Street _____ City _____ State _____ Zip _____

Mailing Address (if different than street address): _____

H. Phone _____ W. Phone _____ Cell Phone: _____

E-mail address: _____ Birth Date _____ Age _____ Sex: M F

If female, is there a possibility that you might be pregnant? YES NO Marital Status: M S W D No. of children _____

Occupation _____ Employer _____

Spouse's Name _____ Spouse's Employer/Occupation _____

Who should we call in an emergency? Name _____ Phone _____

List any surgeries (include date) _____

Previous Injuries: _____

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| Yes | No | Health Habits | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink 2 or more alcoholic beverages each day? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you maintain a good posture? | <input type="checkbox"/> | <input type="checkbox"/> | Do you take nutritional supplements? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise regularly? | <input type="checkbox"/> | <input type="checkbox"/> | Do you consider yourself to be healthy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you eat 5 or more servings of fruits or vegetables each day? | <input type="checkbox"/> | <input type="checkbox"/> | Do you frequently feel emotionally stressed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? | | | |

In the following list, please check all of the conditions that you have experienced in the past year.

HEAD

- Headache
- Migraine
- Head feels heavy
- Vision problems
- Dizziness
- Hearing problems
- Ringing in ears

NECK

- Neck pain
- Grinding sounds in neck

SHOULDERS

- Pain in shoulders
- Can't raise arm

ARMS & HANDS

- Pain in arm
- Pain in hands
- Numbness or tingling in arm

- Numbness or tingling in hands
- Loss of strength in arms
- Loss of strength in hands

BACK

- Upper back pain
- Mid-back pain
- Rib pain
- Pain when breathing
- Low back pain

ABDOMEN - DIGESTION

- Nervous stomach
- Ulcers
- Constipation
- Heart burn
- Hiatal Hernia
- Nausea

HIPS, LEGS & FEET

- Pain in buttocks

- Pain in hip joint
- Pain down upper leg
- Pain down below knee
- Pain in both legs
- Knee pain
- Leg cramps
- Numbness or tingling in legs
- Numbness or tingling in toes
- Swollen ankles

WOMEN ONLY

- Menstrual pain
- Cramping
- Irregularity
- Menopause
- Pre-menstrual Syndrome

MEN ONLY

- Urinary frequency

- Difficulty starting urination
- Night urination

GENERAL

- Nervousness
- Irritable
- Mood swings
- Depression
- Fatigue
- Difficulty sleeping
- Diabetes
- Cancer
- Breathing problems
- Asthma
- Allergies
- Sinus trouble
- Epilepsy
- High blood pressure
- Difficulty losing weight

Other problems: _____

In the boxes below, describe your major complaints

Complaint _____

When did the most recent occurrence begin: _____ Have you had similar problem in the past? Yes No

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint and a "10" would be extreme discomfort.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

How often do you feel symptoms: Constant, or _____ X per day, week, month, year.

Is this condition getting worse? _____ What activities aggravate this condition: _____

Is it worse in the: Morning Mid-day Evening Doesn't Matter

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

Notes _____

Complaint _____

When did the most recent occurrence begin: _____ Have you had similar problem in the past? Yes No

Circle the numbers in the scale below to indicate how bad this complaint is. A "0" would be no complaint and a "10" would be extreme discomfort.

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Is this condition getting worse? _____ What activities aggravate this condition: _____

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

Notes _____

Complaint _____

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Is it worse in the: Morning Mid-day Evening Doesn't Matter

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

Notes _____

