a natural way to better health

CASE HISTORY

Name:____ Date:______________________
Address:______________________________ City:____________________ State:______ Zip:_____
Home Phone:______________________ SSN:________________ Drivers Lic. #:________________
Cell Phone:_______________________ Email:______________________________________
Age:_______ Birthdate:_____________ Sex: M F Status: M S W D No. of Children:_____________
Occupation:__________________________ Employer:________________________ Yrs Employed:_____
Employer's Address:________________________ City:____________________ State:______ Zip:_____
Spouse's Name__________________________ Occupation:_______________ Employer:___________
Person Responsible For This Account:_________________________ Referred By:__________________
What is your major complaint?____
____
Other complaints:____
How long have you had this condition?___________________ Have you had this or similar conditions in the past? Y / N
What activities aggravate your condition?____
Is this condition getting progressively worse? ___Y ___N Constant____ Comes and goes____
Is this condition interfering with your: Work____ Sleep____ Daily Routine____ Other___________________
How long has it been since you felt really good?_____________________________________
List surgical operations:____
____
Are you taking any medications: ___Y ___N What kind?_________________________________
Any non-prescription drugs? ___Y ___N What kind?____________________________________

OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS
X-rays:_____________ Urinalysis:_____________ Blood Tests:______________ Other:____________
Treatment: Medication_________________________ Physiotherapy___________________________
Results:______________________________ Length of time under care_____________________
Were you off work?______ How long?______ Have you returned to the same job?______ If not, why?______________

INSURANCE INFORMATION:
Are you covered by Medicare? ___Y ___N Medicare #:_______________________ State Insurance Aid? ___Y ___N
Do you have any group, union or personal health insurance? ___Y ___N
Insurance Company:______________ Memeber ID:____________________ Group #:______________
Address:____ Phone:___________________
Is your condition due to an accident? ___Y ___N Illness__________ Other___________________________
Did your accident occur while at work? ___Y ___N Were you involved in an auto accident? ___Y ___N Date:________
Time:______
Injury reported to employer? ___Y ___N Supervisor Name:___________________________________
Description of accident:____
____
How were you injured?____
Location:_______________________________ Were you unconscious?_______________________
Fractures:_____________ Cuts:____________ Abrasions:______________ Bruises:_____________
Were you taken to the hospital? ___Y ___N Name of Hospital:______________________________
Confined to hospital for ______ days ______ hours Name of Hospital Dr.:_____________________
Have you had any other personal injury accident: ______ Past year ______ Past 5 years ______ Over 5 years ______None
Do you have an attorney? ___Y ___N Attorney Name and Address:_____________________________

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature:_______________________________________ Date:___________________

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IMPORTANT: Please check (X) all present symptoms.

HEAD:
Headache
- ___ Sinus (allergy)
- ___ Entire head
- ___ Back of head
- ___ Forehead
- ___ Temples
- ___ Migraine

___ Head feels heavy
___ Loss of memory
___ Light-headedness
___ Fainting
___ Light bothers eyes
___ Blurred vision
___ Double vision
___ Loss of vision
___ Loss of taste
___ Loss of balance
___ Dizziness
___ Loss of hearing
___ Pain in ears
___ Ringing in ears
___ Buzzing in ears

NECK:
___ Pain in neck
___ Neck pain with movement
- ___ Forward
- ___ Backward
- ___ Turn to left
- ___ Turn to right
- ___ Bend to left
- ___ Bend to right

___ Pinched nerve in neck
___ Neck feels out of place
___ Muscle spasms in neck
___ Grinding sounds in neck
___ Popping sounds in neck
___ Arthritis in neck

ARMS & HANDS:
___ Pain in upper arm
___ Pain in elbow
___ Movement aggravated
___ Tennis elbow
___ Pain in forearm
___ Pain in hands
___ Pain in fingers
___ Head feels heavy
___ Sensation of pins and needles in arms
___ Sensation of pins and needles in fingers
___ Numbness in arms (R - L)
___ Fingers go to sleep
___ Hands cold
___ Swollen joints in fingers
___ Sore joints in fingers
___ Arthritis in fingers
___ Loss of grip strength

SHOULDERS:
___ Pain in shoulder joint (R - L)
___ Pain across shoulders
___ Bursitis (R - L)
___ Arthritis (R - L)
___ Can't raise arm
- ___ Above shoulder level
- ___ Over head

___ Tension in shoulders
___ Pinched nerve in shoulder (R - L)
___ Muscle spasms in shoulders

MID BACK:
___ Mid-back pain
___ Location:______________________
___ Pain between shoulder blades
___ Sharp stabbing
___ Dull ache
___ Pain from front to back
___ Muscle spasms
___ Pain in kidney area

CHEST:
___ Chest pain
___ Shortness of breath
___ Pain around ribs
___ Breast pain
___ Dimpled or orange peel breast
___ Irregular heartbeat

ABDOMEN:
___ Nervous stomach
___ Foods you can't eat
___ Nausea
___ Gas
___ Constipation
___ Diarrhea
___ Hemorrhoids

LOW BACK:
___ Low back pain
___ Upper lumbar
___ Lower lumbar
___ Sacroiliac
___ Low back pain is worse when:
- ___ Working
- ___ Lifting
- ___ Stooping
- ___ Standing
- ___ Bending
- ___ Coughing
- ___ Lying down (sleeping)
- ___ Walking
- ___ Pain relieved when: _

___ Slipped disk
___ Low back feels out of place
___ Muscle spasms
___ Arthritis

HIP, LEGS & FEET:
___ Pain in buttocks
___ Pain in hip joint
___ Pain down leg
___ Pain down both legs
___ Knee pain
- ___ Inside
- ___ Outside

___ Leg cramps
___ Cramps in feet
___ Pins and needles in legs
___ Numbness of leg
___ Numbness of toes
___ Feet feel cold
___ Swollen ankles
___ Swollen feet

WOMEN ONLY:
___ Menstrual pain _____________(where)
___ Cramping
___ Irregularity
___ Cycle________ days
___ Birth control _______________(type)
___ Hysterectomy
___ Genital Cancer____________________
___ Discharge
___ Menopause
___ Tumors
___ Abortions
___ Are you thinking about getting pregnant?

MEN ONLY:
___ Urinary frequency _________________
___ Difficulty in starting
___ Night urination
___ Prostate pain/swelling

GENERAL:
___ Nervousness
___ Irritable
___ Depressed
___ Fatigue
___ Generally feel run-down
___ Normal sleep _____________hrs/night
___ Loss of sleep _____________hrs/night
___ Loss of weight _________________lbs.
___ Weight gain __________________lbs.
___ Coffee ________________ cups/day
___ Tea ________________ cups/day
___ Cigarettes _______________pack/day
___ Other __________________________
___ Diabetes
___ Hypoglycemia

REMARKS:
____
____
____
____
____

Patient Signature:____ Date:__________________________

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