CONFIDENTIAL CASE HISTORY
Please Print

Name: _____ Phone: H _____ W _____ C _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth (mm/dd/year): __ __ / __ __ / __ __ __ __ Age: ____ M ☐ F ☐ Martial Status: _____ No. of Children: _____

Height: _____ Weight: _____ Email: _____

Occupation: _____ Social Security Number: _____ - _____ - _____

Who is Responsible for this Account? _____ Referred by: _____

1. **PRESENT SYMPTOMS**: 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? Yes ☐ No ☐ If yes, what was the diagnosis? _____

    a. By Whom?: _____ Address: _____

    b. X-rays: _____ Blood work: _____

PAST HISTORY

11. Have you had a similar problem before? Yes ☐ No ☐ If yes, when? _____ What cause those episodes? _____

    What relieved them? _____

12. Did they disable you? _____ Prevent you from working? _____ Hospitalized you? _____

    What was the diagnosis? _____

    What were the treatments? _____ Did they help? _____

    Name of attending physician? _____ Address: _____

Are you on any medications?: _____ List them: _____

Are you taking any of the following?

Habit	Heavy	Moderate	Light	None	Habit	Heavy	Moderate	Light	None
Alcohol					Tobacco				
Coffee					Exercise				
Tea					Sugar				

	Laxatives		Sedatives
	Aspirin		Vitamins
	Sleeping Pills		Minerals
	Insulin		Herbs

Have you ever had any operations? Yes ☐ No ☐ If yes, describe briefly: _____

Broken bones? Yes ☐ No ☐ _____

Accidents or injuries? Yes ☐ No ☐ _____

If yes, did you receive a whiplash? _____

DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING:

	Headache		Sinus trouble		Ringing in ears		Wear glasses
	Shooting head pain		Loss of smell		TMJ Pain		Lights bother eyes
	Face flushed		Hay fever		Twitching of face		Fainting
	Head feels too heavy		Loss of taste				Loss of memory
	Muscle Spasms in neck		Tightness in throat		Neuritis in shoulders and hands		Thyroid trouble
	Grating in Neck		Inflammation of throat		Pins and needles in arms & hands		Cold hands
					Tightness/pain in shoulders		
	Back/low back pain		Painful joints		Pain in groin area		Swollen ankles
	Pinched nerves in back		Swollen joints				Cold feet
	Slipped disc		Arthritis				Pains or numbness/tingling in legs / feet
	Chest pains		High blood pressure		Shortness of breath		Rheumatic fever
	Heart palpitations		Low blood pressure		Heart pain		Asthma
	Heart attacks		Anemia				T.B.
	Indigestion		Kidney trouble		Stomach trouble		Diabetes
	Intestinal gas		Bladder trouble		Nervous stomach		Ulcers
	Persistent abdominal pain		Gall bladder trouble		Nerves and nervousness		
	Constipation		Liver trouble				
	Tire too easily		Inner tension		Depressions		Cold sweats Excessive perspiration
	Fatigue		Irritability		Melancholia of long standing		
	Loss of balance		Dizziness		Sleeping problems		Cancer

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: Yes ☐ No☐ Uncomfortable: Yes ☐ No☐ _____ Bed board: Yes ☐ No☐

Do you use a foam pillow? Yes ☐ No☐ Do you sleep on: Side ☐ Back☐ Stomach☐

Are you wearing: Heel lifts ☐, Sole lifts ☐, Arch supports ☐, Inner soles☐

Signature_____

Date_____