



## 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 \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-Mail \_\_\_\_\_

Marital Status:  M  S  D  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 \_\_\_\_\_



**NEUROLOGIC NOW PAST**

Seizures    
Vertigo    
Dizziness    
Hand Trembling    
Loss of Sensation    
Incoordination    
Loss of Facial    
Weak Grip    
Paralysis    
Difficulty Speech    
Tingling    
Loss of Memory    
Numbness

**ENDOCRINE**

Weight Loss    
Weight Gain    
Extremely Thin    
Heat Intolerance    
Cold Intolerance    
Hair Changes    
Breast Changes

**IMMUNIZATION/VACCINATION**

DPT   
Mumps   
Smallpox   
Typhoid   
Tetanus   
Measles   
Pneumococcal   
Influenza   
Polio   
MMR

**BLOOD TYPE**

A +  A -   
B +  B -   
AB +  AB -   
O +  O -   
Other \_\_\_\_\_

**BLOOD TRANSFUSIONS**

Date \_\_\_\_\_  
Date \_\_\_\_\_  
Date \_\_\_\_\_  
Date \_\_\_\_\_

**PSYCHIATRIC NOW PAST**

Hyperventilation    
Insecurity    
Depression    
Troubled Sleep    
Irritable    
Undecidedness    
Timid    
Hallucinations    
Loss of Memory    
Alcoholism    
Drug Addiction    
Drug Dependent    
Suicidal Thoughts    
Extreme Worry    
Sexual Problems

**PAST MEDICAL HISTORY. Check only the ones you have had in the past.**

Hay Fever  Epilepsy   
Mumps  Paralysis   
Rheumatic Fever  Polio   
Allergies  Mental Illness   
Angina  Alcoholism   
Cancer  Depression   
Tumor  Nervous Breakdown   
Blood Disease  Migraine   
Leukemia  Gout   
Heart Trouble  Hemorrhoids   
Varicose Veins  Prostate Problems   
Phlebitis  Sexual Problems   
Hypertension  Gonorrhea   
Stroke  Syphilis   
Ulcers  Diabetes   
Jaundice  Bladder Trouble   
Skin Trouble  Kidney Stones   
Gallstones  Kidney Infections   
Liver Trouble  Diabetes   
Hepatitis  Bladder Trouble   
Parasites  Dysentery

Date of Last Chest X-Ray \_\_\_\_\_  Normal  Abnormal

Last TB Skin Test \_\_\_\_\_  Normal  Abnormal

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

