

Date: / /

### Patient Case History

All the information that you provide on this questionnaire is strictly confidential, and will become part of your medical record

Name (Last, First, M.I.): \_\_\_\_\_  M  F Date of Birth: / /

Marital Status:  Single  Married  Partnered  Separated  Divorced  Widowed

Primary Care Physician: \_\_\_\_\_ Date of most recent physical exam: \_\_\_\_\_

#### Health Complaints:

As specifically as possible, please describe your **primary** complaint -

What do you believe is causing your **primary** complaint?

How long have you been experiencing your **primary** complaint?

Your **primary** complaint feels?  sharp  radiating  tingling  numb  stabbing  lightning-like  grabbing  burning  cold  dull/achy  \_\_\_\_\_

How often do you experience your **primary** complaint?  constantly  several times a day  daily  weekly  monthly  yearly

Have you sought treatment for your primary complaint by another health care provider?  Yes  No If yes, when? / / (mo/yr)

Whom did you see? \_\_\_\_\_ Ph: ( ) - - Fax: ( ) - -

Have you had diagnostic imaging or testing performed on your primary complaint? (ie: Xray, MRI, CT, NCV, Bone Scan etc.)  Yes  No  
If yes, please bring copies of reports/results, if available, to your first visit. If you don't have reports, we may make arrangements to attain copies.

Select only one box below to describe how your **primary** complaint affects your life.

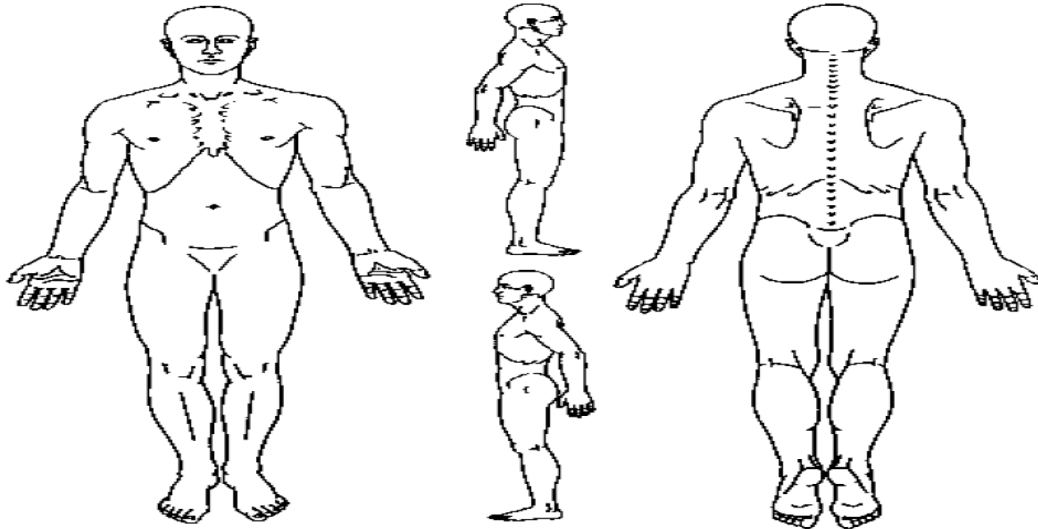
<input type="checkbox"/> no pain or discomfort	<input type="checkbox"/> slight discomfort	<input type="checkbox"/> pain that does not affect my activities	<input type="checkbox"/> pain that DOES affect my activities	<input type="checkbox"/> pain that prevents me from performing my daily activities	<input type="checkbox"/> pain that limits my work schedule	<input type="checkbox"/> pain that prevents me from working at all	<input type="checkbox"/> pain that prevents me from working, and all personal activity	<input type="checkbox"/> pain that keeps me in bed	<input type="checkbox"/> pain that causes thoughts of suicide
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You may often be asked to rate your pain on a "pain scale" from 1-10, with "10" representing the worst pain you have ever felt. Thinking back on your illnesses and injuries, please describe the worst physical pain you have ever felt. \_\_\_\_\_

List other health complaints (2-5).

- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Please mark the areas of **ALL** your complaints. Include descriptive words or comments (ie: sharp, radiating, tingling, numb, burning, cold, achy etc)



Lifestyle and Habits:					
<b>Supplements</b>	Do you take a multi-vitamin consistently? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what brand to you take? _____				
	Please list any nutritional supplements that you currently take.				
	Supplement	Reason	Supplement	Reason	
	1. _____	_____	3. _____	_____	
	2. _____	_____	4. _____	_____	
<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (ie:, climb stairs, walking, golf)		What activity? _____		
	<input type="checkbox"/> Occasional vigorous exercise (less than 4 times a week for 30 minutes)		What activity? _____		
	<input type="checkbox"/> Regular vigorous exercise (4 times a week or more, for at least 30 minutes)		What activity? _____		
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Soda	How many drinks per week?
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what kind?	How many drinks per week?
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes: Cigarettes- packs/day _____, Smokeless- #/day _____, Pipe/Cigar- #/day _____	
	If yes, for how many years have you used tobacco? _____			If a former tobacco user, in what year did you quit? _____	
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Family History:						
Please mark the following conditions as they pertain to your family members' past or present.						
	Mother	Father	Siblings	Grandparents	Children	Significant Other
back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other –please explain						

Conditions: Please indicate below if you currently have, or previously have had any of the following conditions. C = Currently P = Previously														
C	P		C	P		C	P		C	P		C	P	
<input type="checkbox"/>	<input type="checkbox"/>	alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	anxiety	<input type="checkbox"/>	<input type="checkbox"/>	appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	arthritis
<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	cauda equina	<input type="checkbox"/>	<input type="checkbox"/>	depression	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	drug abuse
<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	goiter	<input type="checkbox"/>	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive
<input type="checkbox"/>	<input type="checkbox"/>	hypertension	<input type="checkbox"/>	<input type="checkbox"/>	influenza	<input type="checkbox"/>	<input type="checkbox"/>	low back pain	<input type="checkbox"/>	<input type="checkbox"/>	measles	<input type="checkbox"/>	<input type="checkbox"/>	meningitis
<input type="checkbox"/>	<input type="checkbox"/>	mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	mumps	<input type="checkbox"/>	<input type="checkbox"/>	osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	pleurisy
<input type="checkbox"/>	<input type="checkbox"/>	pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	polio	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	spinal fracture	<input type="checkbox"/>	<input type="checkbox"/>	stroke
<input type="checkbox"/>	<input type="checkbox"/>	TIA "mini stroke"	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	venereal infection	<input type="checkbox"/>	<input type="checkbox"/>	whiplash	<input type="checkbox"/>	<input type="checkbox"/>	whooping cough

**Medical, Hospitalizations, Injuries, Medications:**

**Surgeries, Other Hospitalizations, Sports and/or Job Injuries, Motor Vehicle Accidents:** (list most recent first)

Surgeries		Sports and/or Job Injuries		
Year	Reason	Year	Description	Treatment Received

Other Hospitalizations		Motor Vehicle Accidents		
Year	Reason	Year	Description	Treatment Received

Have you ever been knocked unconscious?  Yes  No If yes, please explain. \_\_\_\_\_

Do you have implanted devices of any kind in your body? (ie: pacemaker, artificial joints, cosmetic implants, screws, plates, cages etc.)  Yes  No  
If yes, please explain. \_\_\_\_\_

List any broken bones or dislocations that you have had. \_\_\_\_\_

Have you ever had a spinal tap or spinal injection?  Yes  No If yes, please explain. \_\_\_\_\_

List any prescription and over-the-counter medications that you are currently taking.

Medication	Reason	Medication	Reason
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

**System Review:** Please indicate below any condition that is of current or recent concern.

**General**

<input type="checkbox"/> anxiety	<input type="checkbox"/> chills	<input type="checkbox"/> convulsions	<input type="checkbox"/> depression	<input type="checkbox"/> dizziness
<input type="checkbox"/> fainting	<input type="checkbox"/> fatigue	<input type="checkbox"/> fever	<input type="checkbox"/> headache	<input type="checkbox"/> nerve pain
<input type="checkbox"/> nervousness	<input type="checkbox"/> night sweats	<input type="checkbox"/> wheezing	<input type="checkbox"/> weight gain	<input type="checkbox"/> weight loss

**Gastro-Intestinal**

<input type="checkbox"/> constipation	<input type="checkbox"/> diarrhea	<input type="checkbox"/> gall bladder disorder	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> jaundice
<input type="checkbox"/> liver dysfunction	<input type="checkbox"/> nausea	<input type="checkbox"/> stomach pain	<input type="checkbox"/> poor appetite	<input type="checkbox"/> poor digestion
<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> reflux	<input type="checkbox"/> vomiting	<input type="checkbox"/> vomiting blood	<input type="checkbox"/>

**Genito-Urinary**

<input type="checkbox"/> difficulty controlling urination	<input type="checkbox"/> blood in urine	<input type="checkbox"/> kidney stone	<input type="checkbox"/> kidney infection	<input type="checkbox"/> bladder infection
<input type="checkbox"/> liver dysfunction	<input type="checkbox"/> nausea	<input type="checkbox"/> stomach pain	<input type="checkbox"/> poor appetite	<input type="checkbox"/> poor digestion
<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> reflux	<input type="checkbox"/> vomiting	<input type="checkbox"/> vomiting blood	<input type="checkbox"/>

**Eyes / Ears / Nose / Throat**

<input type="checkbox"/> allergies	<input type="checkbox"/> dry eyes	<input type="checkbox"/> earache	<input type="checkbox"/> ear discharge	<input type="checkbox"/> ear noise
<input type="checkbox"/> enlarged thyroid	<input type="checkbox"/> frequent colds	<input type="checkbox"/> hearing loss	<input type="checkbox"/> hoarseness	<input type="checkbox"/> nasal congestion
<input type="checkbox"/> nose bleeds	<input type="checkbox"/> poor vision	<input type="checkbox"/> sinus infections	<input type="checkbox"/> sore throat	<input type="checkbox"/> tonsillitis

**Respiratory**

<input type="checkbox"/> asthma	<input type="checkbox"/> chronic cough	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> spitting blood	<input type="checkbox"/> spitting phlegm
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**Muscles / Joints / Bones**

<input type="checkbox"/> foot problems	<input type="checkbox"/> joint pain	<input type="checkbox"/> low back pain	<input type="checkbox"/> muscle twitching	<input type="checkbox"/> neck pain
<input type="checkbox"/> painful tailbone	<input type="checkbox"/> swollen joints	<input type="checkbox"/> tremors	<input type="checkbox"/> upper back pain	<input type="checkbox"/> weakness

**Cardio-Vascular**

Patient Name: \_\_\_\_\_

<input type="checkbox"/> ankle swelling	<input type="checkbox"/> fibrillation	<input type="checkbox"/> heart problems	<input type="checkbox"/> hypertension	<input type="checkbox"/> low blood pressure
<input type="checkbox"/> pain over heart	<input type="checkbox"/> poor circulation	<input type="checkbox"/> rapid or slow pulse	<input type="checkbox"/> stroke	<input type="checkbox"/> TIA "mini strokes"
<b>Skin or Allergies</b>				
<input type="checkbox"/> bruise easily	<input type="checkbox"/> dryness	<input type="checkbox"/> eczema or psoriasis	<input type="checkbox"/> itching	<input type="checkbox"/> sensitive skin
<b>Women Only</b>				
<input type="checkbox"/> cramps	<input type="checkbox"/> excessive flow	<input type="checkbox"/> hot flashes	<input type="checkbox"/> irregular cycle	<input type="checkbox"/> yeast infections
<b>Men Only</b>				
<input type="checkbox"/> difficulty attaining an erection	<input type="checkbox"/> decreased urinary flow	<input type="checkbox"/> frequent nighttime urination	<input type="checkbox"/> inability to empty bladder completely	<input type="checkbox"/> prostate infection or Benign Prostate Hypertrophy (BPH)

<b>Women Only: (Pregnancy)</b>		
We do not knowingly x-ray women who are or may be pregnant. If there is a possibility that you may be pregnant, please inform the doctor right now.		
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	On what date did your last period begin? _____/_____/_____	
Do you want to take a pregnancy test now? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please indicate which of the following situations apply to you.		
Tubal Ligation <input type="checkbox"/> Yes <input type="checkbox"/> No	Complete or Partial Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No	Partner had a vasectomy <input type="checkbox"/> Yes <input type="checkbox"/> No
Taking birth control pills <input type="checkbox"/> Yes <input type="checkbox"/> No	Less than 10 days since the start of my last period <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Is there anything else about your condition or health history that you think we should know about?  Yes  No If yes, please explain below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I fully understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes, and I am requesting these services.
- I understand the importance of completing the clinic's forms in detail, and I accept responsibility for their accuracy.
- It is also my responsibility to notify the doctor immediately upon any change in the condition for which I am being treated in this office, or any other change in my health.
- Original medical records are the property of this clinic. Copies may be released to me upon written request.

\_\_\_\_\_ Patient or Guardian Signature

\_\_\_\_\_ Date