CASE HISTORY

Date_____
Name _____ Phone (Home) _____ Phone (Cell) _____
Date of Birth_____ E-mail_____
Address_____Age_____ Sex: M F
City_____State_____Zip_____ Marital Status: S M D W
Occupation _____ Employer_____ Telephone (Work) _____
Spouse's Name_____ Spouse's Occupation_____
Spouse's Employer _____ Spouse's Telephone (Work) _____
Referred By _____ Doctor's Name _____ Results _____
Chief Complaint 1. _____
2. _____
3. _____
Insurance Company _____ Telephone _____
Social Security # _____ Driver's License # _____
Spouse's Insurance Co. _____ Telephone _____
Spouse's Social Security # _____ Spouse's Driver's License # _____

Habits

- ❑ Smoking Packs/Day _____
- ❑ Drinking Alcohol _____
- ❑ Coffee Cups/Day _____

Exercise

- ❑ None
- ❑ Moderate
- ❑ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	□	□	□	□	□
Father	□	□	□	□	□
Brother, No. of ____	□	□	□	□	□
Sister, No. of _____	□	□	□	□	□

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

Check which of the following applies to you:

_____ 541 Appendicitis
_____ 541 Pneumonia
_____ 541 Rheumatic Fever
_____541 Polio
_____ 541 Tuberculosis
_____541 Whooping Cough
_____ 285.9 Anemia
_____ 285.9 Measles
_____ 285.9 Mumps
_____ 285.9 Chicken Pox
_____ 285.9 Diabetes
_____ 285.9 Cancer
_____ 429.9 Heart Disease
_____429.9 Goiter
_____ 429.9 Influenza
_____ 429.9 Pleurisy
_____ 429.9 Alcoholism
_____ 429.9 Venereal Infection
_____716.9 Arthritis
_____716.9 Epilepsy
_____ 716.9 Mental Disorder
_____ 716.9 Lumbago
_____716.9 Eczema
_____ AIDS

GENERAL SYMPTOMS

_____ 784.0 Headache
_____ 780.6 Fever
_____ 780.9 Chills
_____ 780.8 Night Sweats
_____ 780.2 Fainting
_____ 780.4 Dizziness
_____ 780.3 Convulsions
_____ 780.52 Loss of Sleep
_____ 780.7 Fatigue
_____ 799.2 Nervousness
_____ 783 Loss of Weight
_____ 782 Numbness or pain in arms/legs/hands
_____995.3 Allergy (What)
_____786.09 Wheezing
_____729.2 Neuralgia

GASTRO-INTESTINAL

_____ 783 Poor Appetite
_____ 536.8 Poor Digestion
_____ 994.2 Excessive Hunger
_____ 787.3 Belching or Gas
_____ 787 Nausea
_____ 787 Vomiting
_____ 578 Vomiting Blood
_____ 536.8 Pain over Stomach
_____ 564 Constipation
_____ 558.9 Diarrhea
_____ 789 Colon Trouble
_____ 455.6 Hemorrhoids (Piles)
_____ 785.1 Liver Trouble
_____ 782.4 Jaundice
_____ 575.9 Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

_____ 368.9 Poor Vision
_____ 378.9 Crossed Eyes
_____ 379.91 Pain in Eyes
_____ 389.9 Deafness
_____ 388.30 Ear Noises
_____ 388.60 Ear Discharge
_____ 478.1 Nasal Obstruction
_____ 784.7 Nose Bleeds
_____ 462 Sore Throats
_____ 784.49 Hoarseness
_____ 477.9 Hay Fever
_____ 493.9 Asthma
_____ 460 Frequent Colds
_____ 240.9 Enlarged Thyroid
_____ 463 Tonsillitis
_____ 686.9 Sinus Trouble

RESPIRATORY

_____ 786.2 Chronic Cough
_____ 786.3 Spitting Blood
_____ 933.1 Spitting Phlegm
_____ 786.50 Chest Pain
_____ 786.09 Difficulty Breathing

GENITO-URINARY

_____ 788.3 Frequent Urination
_____ 788.1 Painful Urination
_____ 599.7 Blood in Urine
_____ 592 Kidney Infection
_____ 788.3 Bed Wetting
_____ 788.1 Inability to control Urine
_____ 601.9 Prostate Trouble

MUSCLES & JOINTS

_____ Weakness
_____ Twitching
_____ 847 Stiff Neck
_____ 722.10 Backache
_____ 719 Swollen Joints
_____ 781 Tremors
_____ 729.5 Foot Trouble
_____ 724.79 Painful Tail Bone
_____ 724.5 Pain Between Shoulders
_____ 563.3 Hernia
_____ 737.3 Spinal Curvature

CARDIO-VASCULAR

_____ 783 Rapid Heart
_____ 427.89 Slow Heart
_____ 401.9 High Blood Pressure
_____ 458.9 Low Blood Pressure
_____ 786.51 Pain over Heart
_____ 438 Previous Heart Trouble
_____ 719.07 Swelling Ankles
_____ 759.9 Poor Circulation
_____ Varicose Veins
_____ 436 Strokes

SKIN OR ALLERGIES

_____ 368.9 Skin Eruptions
_____ 698.9 Itching
____ 278.8 Bruising Easily
_____ 701.1 Dryness
_____ Boils
_____ 782 Sensitive Skin
_____ 708.9 Hives or Allergy
_____ 692.9 Eczema
_____ Medicines
_____
_____

FOR WOMEN ONLY

_____ 786.2 Painful Periods
_____ 626.2 Excessive Flow
_____ 626.4 Irregular Cycle
_____ 627.2 Hot Flashes
_____ 625.3 Cramps or Backaches
_____ 634.9 Miscarriage
_____ 623.5 Vaginal Discharge
_____ Pregnant at this time
_____ Last Pap
By Whom _____
Other _____

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other

List any accidents or falls and dates: □ Car _____ □ Recreational Vehicle_____ □ Sports _____
□ School _____ □ Other _____
List any broken bones (fractures) or dislocations: _____
Ever on crutches? □ Yes □ No Why ? _____
Have you ever had any spinal taps or spinal injections? □ Yes □ No
Were you ever knocked unconscious? □ Yes □ No
Have you ever had a lapse of memory? □ Yes □ No
Have you ever had X-rays taken? □ Yes □ No When? _____ By Whom? _____
For what ailments were these X-rays made?_____
Do you suffer from any condition other than that for which you are now consulting us? _____
_____
Are you presently taking any medication – prescription or over-the- counter? □ Yes □ No What drugs?_____

** I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service.
Patient's Signature_____ Date_____