PATIENT CASE HISTORY RECORD

Please complete the following information to help us serve you.

Name:_____ Date: _____

If your complaints are the result of an accident, please answer the following questions?

What type of accident was it?

☐ Auto Accident ☐Work Injury ☐A Slip and Fall ☐Other: _____

What was the date of the accident/injury? _____

What are your current activities and hobbies? _____

Are your current problems affecting these activities or hobbies? YES / NO

PAST SURGICAL HISTORY – Please list any surgeries.

1._____Year_____ 3._____Year_____

2._____Year_____ 4._____Year_____

PAST MEDICAL HISTORY – Please check those conditions that you have had in the past:

☐ AIDS/HIV	☐ Emphysema	☐ Knocked Unconscious	☐ Prostate Problems
☐ Anemia	☐ Epilepsy	☐ Learning Disability	☐ Psoriasis
☐ Arthritis	☐ Fainting	☐ Light Headed Upon Rising	☐ Rheumatoid Arthritis
☐ Asthma	☐ Fractured Bones	☐ Liver Trouble	☐ Ringing In Ears R/L
☐ Bedwetting	☐ Frequent Colds/Flu's	☐ Low Back Pain/Stiffness R/L	☐ Scoliosis
☐ Blurred or Double Vision	☐ Gall Bladder Trouble	☐ Lung Problems	☐ Sinus Problems
☐ Cancer	☐ Goiter	☐ Lupus Erythamatosis	☐ Skin Problems
☐ Colon Trouble	☐ Gout	☐ Menopausal Problems	☐ Stroke
☐ Depression	☐ Headaches/Migraines	☐ Menstrual Problems/PMS	☐ Swollen/Painful Joints
☐ Diabetes	☐ Heart Problems	☐ Mid Back Pain/Stiffness R/L	☐ Thyroid Problems
☐ Diarrhea/Constipation	☐ Heartburn	☐ Multiple Sclerosis	☐ Trouble Sleeping
☐ Difficulty Breathing	☐ Hepatitis	☐ Neck Pain/Stiffness R/L	☐ Tuberculosis
☐ Digestive Problems	☐ High/Low Blood Pressure	☐ Numbness/pain in buttocks, thighs, legs, feet, toes R/L	
☐ Dizziness	☐ Hip Pain R/L	☐ Numbness/pain in arms, hands, fingers R/L	
☐ Ear Infection	☐ Hypoglycemic	☐ Polio	☐ Ulcers
☐ Eczema	☐ Kidney Problems	☐ Pregnant (now)	☐ Upper Back Pain/Stiffness R/L
			☐ Other: _____

PERSONAL HABITS

☐ Smoking ____packs/day
☐ Coffee/Tea ____cups/day
☐ Alcohol ____drinks/day
☐ Driving ____hours/day
☐ Soda Pop ____cans/day

EXERCISE

☐none at all
☐occasional ____x/month
☐moderate ____x/week
☐daily

PRESENT MEDICATIONS

1._____
2._____
3._____
4._____
5._____

FAMILY HISTORY

	N/A	Diabetes	Heart	Kidneys	Cancer	Back Problems	Other
Mother	☐	☐	☐	☐	☐	☐	☐ _____
Father	☐	☐	☐	☐	☐	☐	☐ _____
Sister	☐	☐	☐	☐	☐	☐	☐ _____
Brother	☐	☐	☐	☐	☐	☐	☐ _____