Confidential Case History

Please Print Dr. Mr. Mrs. Ms. Miss. Patient#_____

Name:_____ Home#: ( )_____ Work#: ( )_____

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

SS#:_____ Date of Birth:_____ Age:_____ Sex M F

Occupation:_____ Employer:_____ Yrs. Employed:_____

Marital Status:_____ Spouse's Name:_____ Spouse's Occupation:_____

If retired, former occupation:_____ Education level obtained:_____

Primary Care Physician (name, address and telephone):_____

_____

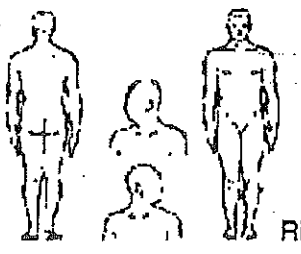
PLEASE PROVIDE EMAIL ADDRESS:

MAIN COMPLAINT: Why are you here today? Be specific with location:_____

_____

1. When did it start? Date: _____
2. How did it start? Explain _____
3. Work-related injury? Y N Auto accident? Y N Injury at home? Y N
   Injury elsewhere? Y N
4. Does it radiate to any other part of your body? Y N Where?_____
5. Did it begin gradually or suddenly? _____
6. How would you describe the intensity? (mild, moderate, severe) _____
7. Describe your pain (dull, sharp, burning, numbness, soreness, stiffness) other _____
8. Has your problem been getting better, worse or about the same? _____
9. Does your condition come and go or is it all the time?_____
10. What makes your symptoms better?_____
11. What makes your symptoms worse?_____
12. Have you tried home remedies? Y N What?_____
13. What doctors have you seen and what tests have been done for your condition?_____
14. Have you had anything like this before? Y N, Details_____
15. Have there been any other changes in any body functions? Y N Details_____
16. Has your condition affected your daily activities in any way? Y N Explain_____
17. Have you been unable to work as a result of your current problem?_____
18. Do you have any other problems that you would like the doctors to evaluate?_____

MARK THE AREAS ON YOUR BODY WHERE YOU HAVE SYMPTOMS.



Left Side Right Side

Past History:

1. Have you had any of the following childhood diseases: (circle) Measles, rubella, chickenpox, mumps, scarlet fever, rheumatic fever, tuberculosis. Other?_____
2. Have you been diagnosed with any other conditions? Y N Explain:_____
3. Are you under a doctor's care presently for any type of health problem?_____
4. Have you had any broken bones? Y N Which ones?_____
5. Have you ever had any past significant auto accidents, work injuries or falls? Y N When?_____
6. Are you taking any medication? Please list._____
7. Have you ever undergone any type of surgery? What and when?_____
8. Do you smoke, drink alcohol or use recreational drugs?_____
9. Do you have any allergies to medications? Y N If yes, please list_____
10. Do any diseases run in your family?_____
11. Do you have a living will? Y N

HAVE YOU BEEN DIAGNOSED OR BEEN TOLD YOU HAVE THE FOLLOWING?

Y	N	High blood pressure
Y	N	Hardening of the arteries
Y	N	Diabetes
Y	N	Heart or blood vessel disease
Y	N	Bone spurs on the neck
Y	N	Whiplash injury
Y	N	Any relatives ever suffer a stroke?
Y	N	Blurred vision
Y	N	Double vision
Y	N	Do you currently smoke?
Y	N	Have you smoked in the past?

MEN ONLY:
Date of last prostate exam: _____

Difficulty with urination? _____

Excessive urination? _____

WOMEN ONLY:
Do you experience any of the following symptoms?

Y	N	Do you take birth control pills? How long? _____
Y	N	Menstrual pain
Y	N	Cramping
Y	N	Irregularity Date of last period _____
Y	N	Are you pregnant? How long? _____

HAVE YOU HAD ANY OF THESE FOLLOWING SYMPTOMS FOR EVEN A SHORT OR TEMPORARY DURATION WITHIN THE LAST YEAR?

Y	N	Slurred speech or other speech problems
Y	N	Difficulty swallowing
Y	N	Dizziness
Y	N	Temporary lack of understanding
Y	N	Loss of consciousness, even momentary blackouts
Y	N	Numbness or loss of sensation in the face, arms, hands, fingers, or legs
Y	N	Any other abnormal or loss of sensation in any other part of your body
Y	N	Weakness, clumsiness, or strength loss in the face, arms, hands, fingers, or legs
Y	N	Sudden collapse without loss of consciousness
Y	N	Diminished or partial loss of vision in one or both eyes
Y	N	Hearing loss in one or both ears

ATTENTION- Payment is to be made at the time of the visit unless prior arrangements have been made with this office. Also a 24-Hour notice is necessary to cancel an appointment, and you may be responsible for payment of a missed appointment.

I hereby consent to any procedures or treatments necessary for treatment of any condition as deemed reasonable by the attending doctor.

Patient signature _____ Date_____

Patient Name: _____ Date: _____

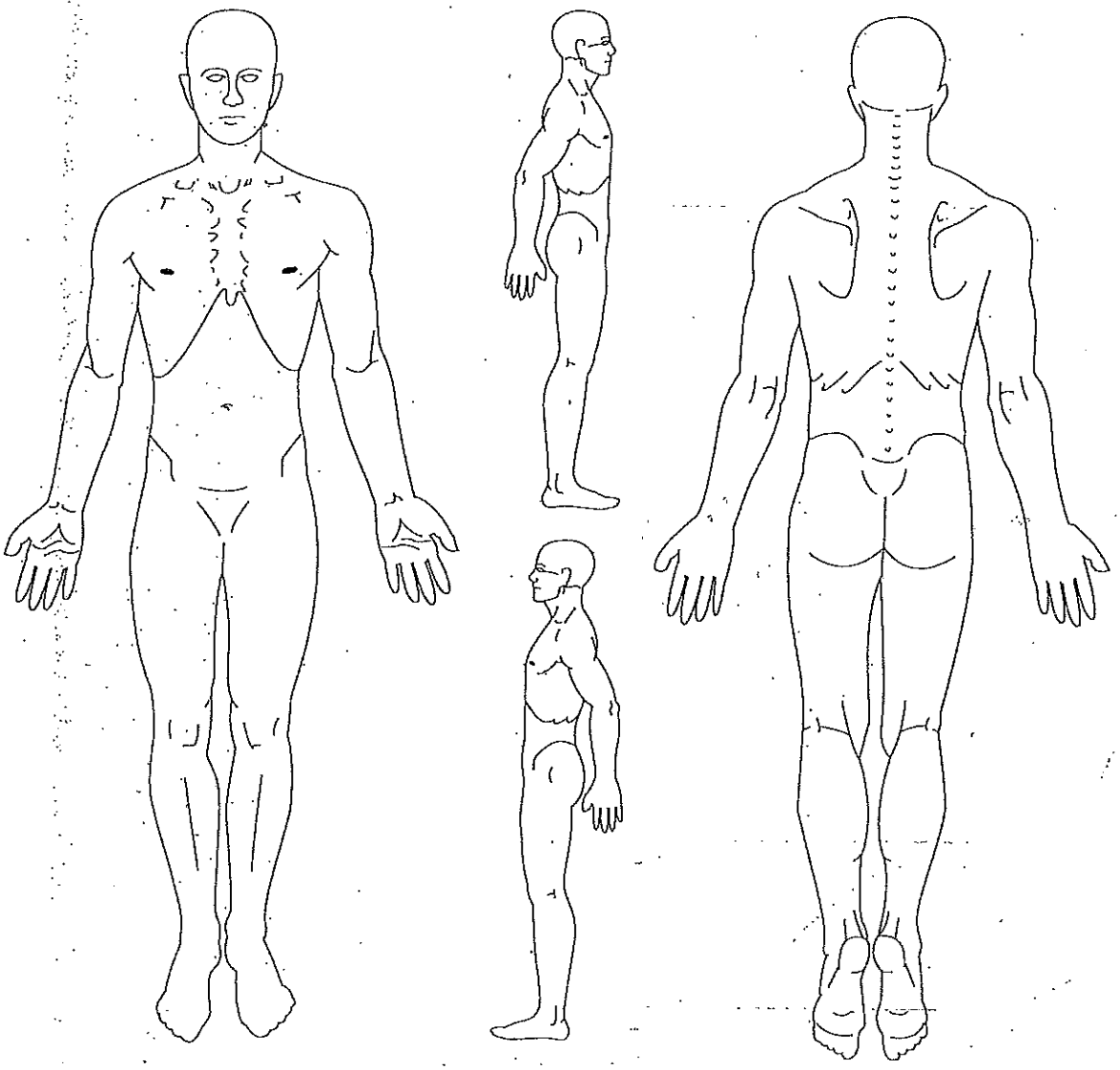
Borg Pain Scale: DOB: _____

On a scale of 1 to 10 place an X in your current pain level.

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
( ) 0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

RANSFORD PAIN DRAWING:

To help us better understand the nature and original of your complaints. We will ask that you carefully complete this drawing. Use the symbols listed below to detail where you hurt and how it hurts.



/ / / / / / / /	Dull Ache/ Throb	========	Numbness
xxxxxxxx	Sharp/ Stabbing	: : : : : : : :	Tingling
BBBBBBBB	Burning	SSSSSSSS	Cramping

_____ _____

Signature of Patient Date