

CONFIDENTIAL PATIENT CASE HISTORY



Name _____

DOB _____

Home _____

Age _____

Address _____

of children _____

Marital Status S M D W

Work # _____

Spouse's Name _____

Home # _____

Spouse's Phone _____

Other _____

E-mail _____

Employer _____

Referred by: _____

SS# _____

HEALTH INFORMATION

What is your major complaint? _____

Other complaints: _____

How long have you had this condition (approximate date)? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? YES NO CONSTANT COME & GOES

Is this condition interfering with your: WORK SLEEP DAILY ROUTINE OTHER _____

How long has it been since you really felt good? _____

Other doctors who treated this condition: _____

List surgical operations and years: _____

Drugs you now take: NERVE PILLS PAIN KILLERS MUSCLE RELAXERS "PEP" PILLS
 TRANQUILIZERS INSULIN BIRTH CONTROL OTHER _____

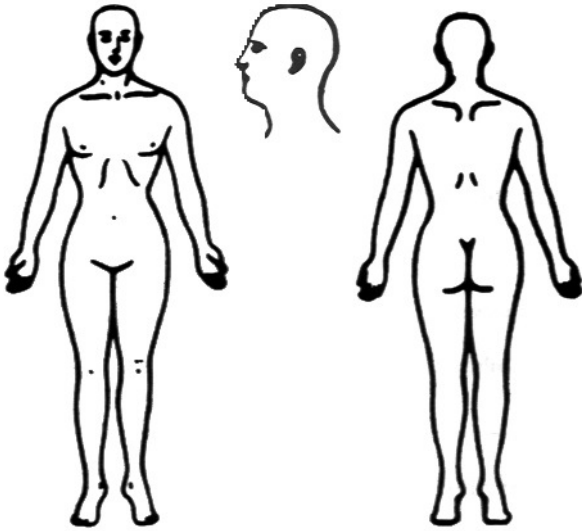
Age of mattress _____ COMFORTABLE UNCOMFORTABLE

Are you wearing: HEEL LIFTS SOLE LIFTS INNER SOLES ARCH SUPPORTS

Have you been in an auto accident? PAST YEAR PAST 5 YEARS OVER 5 YEARS NEVER

Describe _____

Date of Last Physical Examination _____



Have you ever suffered from?

- | | | |
|------------------------|------------------------------|-----------------------------|
| 1. Dizziness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Backaches | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Heart trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Arthritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Headaches | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Neuritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Digestive Disorders | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Nervousness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Sinus trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Neck pain | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? YES NO

Do you have health insurance? YES NO

Name of Company _____ Policy # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Medical Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Medical Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Date _____

Guardian or Spouse Signature: _____

SS# _____

Doctor's Signature: _____

Date _____