

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Name _____ Birth date _____ Age _____ Sex M F
Nombre Fecha de nacimiento Edad Sexo

Address _____ City _____ Zip _____
Direccion Ciudad Zip

Soc. Sec. # _____ Driver's Lic. #: _____ Insurance Company _____
Seguro Social

Home Phone _____ Work Phone _____ E-Mail _____
Telefono de Casa Telefono de Trabajo E-Mail

Cell Phone _____ Pager _____ Fax Number _____
Telefono de celular Telefono de beeper Telefono de fax

Marital Status: M S D W Children, Ages _____ Spouse's Name _____
Estado Civil Hijos, Edad Nombre Esposa(o)

Occupation _____ Employer _____
Ocupacion Empleador

Who referred you to us? _____ How else did you hear about us? _____
Referido por?

What is your major complaint? _____

Is this the result of any type of injury? Describe: _____

Does it radiate anywhere? _____ Where? _____ How long have you had this condition? _____

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

What positions make it feel worse? _____

What positions make it feel better? _____

Is this condition: Improved Unchanged Getting Worse Have you lost work time? _____ How much? _____

Is this condition interfering with your: Work Sleep Daily Routine Other (Describe) _____

Other doctors or therapists who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and dates: _____

Do you have a family physician? Name, address & phone: _____

Medications, dosage and frequency: _____

Have you been in an auto accident or had any other personal injury? Y N Describe _____

Do you have a regular exercise program? _____ Do you take vitamins or nutritional products? _____

What is most important to you in a Doctor/Patient relationship? _____

What is most important to you in life? _____

I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable. If collection efforts are required, I agree to pay all expenses including collection fees, attorney's fees, interest and court costs

Signature _____ Date _____

Parent/Guardian _____ Date _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per week _____ Type _____

Smoking Current Previous Packs/Day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine (Coffee, Tea, Cola) Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.

Use the following symbols:

Aches □□□□ Numbness oooo Pins/Needles ···· Stabbing ////

MARK AN "X" ON THE LINES:

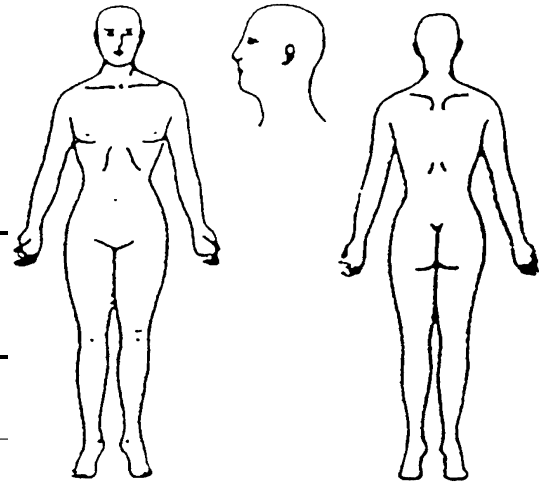
How bad are your symptoms now?

None (0) _____ Most Severe (10) _____

How bad have they been in the past?

None (0) _____ Most Severe (10) _____

Do Not Write Below This Line



O: _____

P: _____

Q: _____

R: _____

S: _____

T: _____