

# CONFIDENTIAL PATIENT CASE HISTORY

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

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Sex  M  F  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Soc. Sec # \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Marital Status:  M  S  D  W Children, Ages \_\_\_\_\_ Email \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Birthday \_\_\_\_\_ Is Spouse the Insured?  Yes  No  
Who referred you to us? \_\_\_\_\_ How else did you hear about us? \_\_\_\_\_  
What is your major complaint? \_\_\_\_\_

When did the condition begin? \_\_\_\_\_  
What do you think caused this condition? \_\_\_\_\_  
Have you had this or similar conditions in the past? \_\_\_\_\_  
Do any positions make it feel worse? \_\_\_\_\_  
Do any positions make it feel better? \_\_\_\_\_

Is this condition:  Improved  Unchanged  Getting Worse  
Is this condition interfering with your:  Work  Sleep  Daily Routine Other \_\_\_\_\_  
Other doctors or therapists who have treated THIS condition: \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Do you have a family physician? Name \_\_\_\_\_  
May we contact your physician regarding your care? \_\_\_\_\_

**Medications, dosage and frequency:** \_\_\_\_\_

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

**FAMILY HISTORY:** (Indicate whether, mother, father, brother/sister, or grandmother/grandfather, and age of onset if known)

Heart disease: \_\_\_\_\_ High blood pressure: \_\_\_\_\_ Stroke: \_\_\_\_\_  
Diabetes: \_\_\_\_\_ Cancer: \_\_\_\_\_ Psychological: \_\_\_\_\_  
Arthritis: \_\_\_\_\_ Osteoporosis: \_\_\_\_\_ Other: \_\_\_\_\_

**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 Pack/Day \_\_\_\_\_ No. of years \_\_\_\_\_

Alcohol  Beer  Liquor  Wine Servings/Week \_\_\_\_\_ No. of years \_\_\_\_\_

**MARK YOUR AREAS OF YOUR SYMPTOMS ON THE FIGURE BELOW.**

Use the following symbols:

Aches  Numbness  Pins/Needles +++++ Stabbing ////

**MARK AN "X" ON THE LINES:**

How bad are your symptoms now?

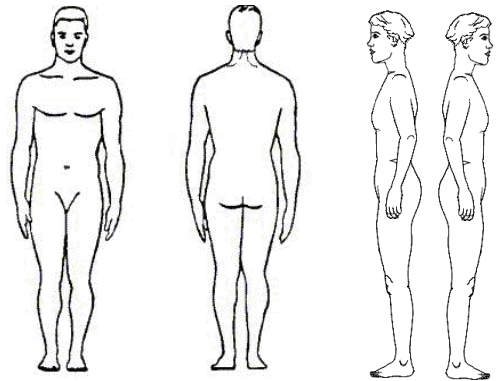
Severity:  
Least Pain 1 \_\_\_\_\_ 10 Most Pain

How bad have they been in the past?

Severity:  
Least Pain 1 \_\_\_\_\_ 10 Most Pain

Frequency:

- Occasional 0-25%  Intermittent 26-50%
- Frequent 51-75%  Constant 76-100%



NOTES: \_\_\_\_\_

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Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_