PRINT CLEAR FORM EMAIL FORM

CASE HISTORY

Name_____
SS#_____

Present complaints and symptoms_____
_____
What do you believe caused your problem/pain? _____
_____
When did you first notice this problem/pain?_____
What problems or activities aggravate your condition?_____
_____
_____

Have you been treated for this problem elsewhere? Yes_____ No_____
If yes, Where_____When_____
Doctor's Names_____Diagnosis_____
Length of Treatment_____Results_____
Have you ever had the same or similar condition?_____

Are you taking any medications? Yes_____ No_____ If yes, please list_____
_____

Have you missed work because of this condition? Yes_____ No_____

Do you use any of the following? Tobacco_____ Quantity_____
Alcohol_____ Quantity_____
Coffee_____ Quantity_____
Tea_____ Quantity_____

What is your level of physical exercise? None_____ Minimal_____ Moderate_____ Heavy_____
What surgeries/operations have you had and what year were they performed? _____
_____
When was your last physical examination?_____ Doctor_____
Have you been in any: Automobile accidents_____ When_____
Falls down stairs_____ When_____
Falls down ladders_____ When_____
Others (List) _____When_____
Please list any broken bones or dislocations_____
Please list what diseases you have had. (Example: Chicken Pox, Diabetes, Cancer etc.)_____
_____
Please list any x-rays taken within the last two years_____
Please describe your family's health history
Father- Living_____ Good Health_____ Diseases (List)_____
Deceased_____ Cause of Death_____
Mother- Living_____ Good Health_____ Diseases (List)_____
Deceased_____ Cause of Death_____
Brother- Living_____ Good Health_____ Diseases (List)_____
Deceased_____ Cause of Death_____
Sister- Living_____ Good health_____ Diseases (List)_____
Deceased_____ Cause of Death_____
Comments_____

Females Only

Is it possible you are pregnant at this time? Yes_____ No_____
Explain_____
Have you had breast implant surgery? Yes_____ No_____