

Case History

Please Print

Patient Name _____ D.O.B. _____ Date _____

History of Present Illness

Approximately when did the conditions or symptoms begin to occur? _____ (date)

Is this the result of a work injury? Yes No Or an Auto Accident? Yes No

Describe the conditions, symptoms or purpose of the appointment: _____

Social

Do you smoke? Yes No Do you drink alcohol? Yes No
Number of packs (per week) _____ Number of drinks (per week) _____

Female patient: Are you pregnant? Yes No Unsure but could be
Date of last menstrual cycle: _____ Regular Irregular Using Birth control?

Medications

Please list any current medications:

I will provide a list of medications.

1 _____ Prescribed for: _____
2 _____ Prescribed for: _____
3 _____ Prescribed for: _____
4 _____ Prescribed for: _____

Allergies

Please list any known allergies, and allergies to medications.

1 _____ 3 _____
2 _____ 4 _____

Past Medical History

List any past surgeries (including appendix, tonsils, wisdom teeth, etc)

1 _____ 2 _____
3 _____ 4 _____

List any other hospitalizations & when & for what _____

List any major or minor falls & when they occurred _____

List any cracked or broken bones & when they occurred _____

Vitals

To be filled in by the office staff.

Height _____ ins. Weight _____ lbs _____ ozs Blood Pressure _____ / _____ mmHG Right Left Pulse _____ BPM Right handed
 seated? Left handed

Signed _____ Date _____ / _____ / _____

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Additional Information Related to the Condition:

Describe your pain: Burning Sharp Dull Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the patient ever had the same or similar symptoms to this condition? Yes No

When? ____ / ____ / ____

Describe _____

Please indicate any other healthcare providers who the patient has seen for the condition:

Name	Type of Licensure	Date of Last Visit
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____

Have you missed work or school due to your injuries? Yes No

Review of Systems

Have you experienced any of the below symptoms in the past 2 weeks or since your last visit?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Tension | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pain in legs/feet |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Sharp / shooting pain |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Numbness arms/hands | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Ears ring |
| <input type="checkbox"/> Coldsweats | <input type="checkbox"/> Feet cold | <input type="checkbox"/> Pain in arms/hands | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Loss of Strength - Arms | <input type="checkbox"/> Constipation | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Chest pain/rib pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Loss of strength - legs | <input type="checkbox"/> Numbness legs/feet | _____ |
| <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fever | _____ |

Changes in Systems

Have you experienced changes to any of the following?

- Eyes (sight) Ears (hearing) Nose (smell) Mouth (taste) Bladder
- Bowels Sleep Emotion Appetite Please Explain: _____

Have you been diagnosed with or experienced any of the following?

- Fatigue Depression Osteopenia/Osteoporosis Heart Disease Stroke Tuberculosis
- Obesity Diabetes Degenerative Joint/Disc Disease Autoimmune Disorder _____
- Prostate Disorder Kidney problems High blood pressure Cancer _____
- Thyroid Problems Asthma Ulcer Seizure Disorder Other _____

Signed _____ Date ____ / ____ / ____