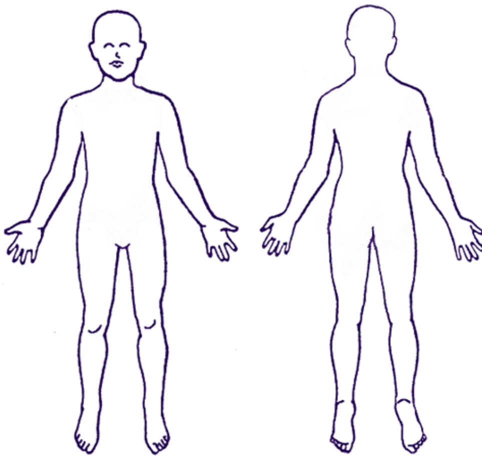
Confidential Case History

Name ____Age _________Date_____________ ___________
Address ____ City ________________ Province_____ Code_________
Phone (Home) __________________ Date of Birth __________________Sex: M F Marital Status: S M D W
What is your major complaint?____
Other complaints____
Have you been treated for any health condition by a physician in the past? __ Yes __ No
If yes, explain: ____
Are you currently taking medication? Yes/No List medications: _______________________________________
Have you broken any bones? Yes/No Have had a concussion? Yes/No Knocked unconscious? Yes/No
Have you had emotional disorders?__________________________Date__________________________________
List the approximate dates of any surgery or treated conditions:____
Age of Mattress_____________________How many pillows?___________Sleep position____________________

Family History: Health conditions.
Father: ______________________ Mother _____________________ Siblings______________________________
Do you smoke Y/N ____
Do you take Vitamins/Supplements Yes/No If yes, type and how often _____________________________________

Please circle and assign a degree of pain to your problem area(s), **0 is no pain, 10 is severe pain.**



What activities aggravate your condition/pain?____
What activities lessen your condition/pain?____
Is this condition interfering with Work?__________ Sleep?__________Routine?_______Other?____________
Is this condition progressively getting worse?___________
In case of emergency, supply the name and # of a close friend or relative________________________________
____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems Itching
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain behind eyes
__ Poor Vision
__ Sinusitis
__ Sore Throat
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Blood in Sputum
__ Difficulty breathing

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising easily
__ Dryness
__Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy

FOR WOMEN ONLY
__ Birth Control
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient
Signature____Date___________________________