

**Today’s Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_**

**CONFIDENTIAL PATIENT CASE HISTORY**

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

**PATIENT INFORMATION**

Patient Title: \_\_\_ Mr. \_\_\_ Mrs. \_\_\_ Mr. \_\_\_ Miss. \_\_\_ Dr. \_\_\_ Prof. \_\_\_ Rev.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suffix ­­\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender:** \_\_\_ Male \_\_\_ Female \_\_\_ Unspecified **Martial Status:** \_\_\_ Single \_\_\_ Married \_\_\_ Other

Race/Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Time\_\_\_ Part Time\_\_\_

Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Contact (check one) \_\_\_ Cell Phone \_\_\_ Work Phone \_\_\_ Home Phone \_\_\_ Email

Would you like text reminders of your appointments? Yes No

Emergency Contact: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us or how did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

Doctor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you want us to send reports to your primary care physician?** Yes No

**INSURANCE INFORMATION**

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANKS WHERE APPROPRIATE**

Reason for appointment? ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your condition begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other doctors involved in treating this condition (list Dr Names) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How has your current condition affected your life? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel this condition could cause limitations in your life 3 to 5 years from now? Yes No

Do you feel this condition is affecting your relationship with friends and family? Yes No

If yes list 2 to 3 limitations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you diabetic or pre-diabetic? Yes No Are you looking for natural options for support? Yes No

Do you feel you are overweight? Yes No Are you looking for natural options for support? Yes No

**SOCIAL HISTORY**

Height: \_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_ Recently lost or gained weight? Yes No How Much? \_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: Beer > \_\_\_\_\_ Glasses/Wk Liquor > \_\_\_\_\_\_ Glasses/Wk Wine > \_\_\_\_\_\_\_\_ Glasses/Wk

Caffeine: Coffee, Tea, or Soda: \_\_\_\_\_ Glasses/Wk \_\_\_ **Aspirin:** No/Day \_\_\_\_\_\_ How Long?\_\_\_\_\_\_

Tobacco: Do you smoke? Yes Never Smoked Former smoker

If yes how many packs do you smoke? \_\_\_\_\_\_\_ packs/day \_\_\_\_\_\_\_ packs/week

If yes, what is your interest in quitting smoking? (Circle one) None Very Little Some Very Interested

Mental Work: Heavy Moderate Light Hours Per Day:\_\_\_\_\_\_

Physical Work: Heavy Moderate Light Hours Per Day:\_\_\_\_\_\_\_

Exercise: Heavy Moderate Light Hours Per Day:\_\_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION & SUPPLEMENTS** Check Here if **NOT** taking any medications

Current Medication and Supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Asthma | Yes | No |
| Shortness of Breath | Yes | No |
| Stomach Ulcers | Yes | No |
| Colitis | Yes | No |
| Rectal Bleeding | Yes | No |
| Hemorrhoids | Yes | No |
| Colon Polyps | Yes | No |
| Anemia | Yes | No |
| Jaundice | Yes | No |
| Liver Disease | Yes | No |
| Hepatitis | Yes | No |
| Bladder Infection | Yes | No |
| Kidney Disease | Yes | No |
| Diabetes | Yes | No |
| Low Blood Sugar | Yes | No |
| Cancer | Yes | No |
| Bleeding Tendency | Yes | No |
| AIDS | Yes | No |

**HEALTH HISTORY -** Please indicate if you have had any of the following (Please include date)

|  |  |  |
| --- | --- | --- |
| Stroke | Yes | No |
| Migraine Headaches | Yes | No |
| Epilepsy or Convulsions | Yes | No |
| Depression or Anxiety | Yes | No |
| High Blood Pressure | Yes | No |
| Chest Pains, Angina | Yes | No |
| Chest Palpitations, Fast or Irregular Heartbeat | Yes | No |
| Heart Murmur | Yes | No |
| Congenital Heart Disease | Yes | No |
| Rheumatic Fever | Yes | No |
| Pneumonia | Yes | No |
| Tuberculosis | Yes | No |
| Emphysema | Yes | No |
| Bronchitis or Chronic Cough | Yes | No |
| Thyroid problems | Yes | No |
| leukemia | Yes | No |
| Rheumatoid Arthritis | Yes | No |

Are you vaccinated from COVID-19? Yes No

If Yes, How many times and what vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had COVID-19? Yes No If Yes, how many times? \_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

**Arthritis**: Parent Sibling **Heart Disease:** Parent Sibling **Thyroid:** Parent Sibling

**Diabetes:** Parent Sibling **Hypertension:** Parent Sibling **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cancer:** Parent Sibling **Stroke:** Parent Sibling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGERIES AND MISC PAIN**

**Please list any surgical procedures you have had and year or surgery**

Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_ Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_

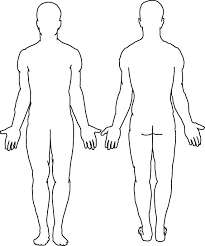
Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_ Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_

**Please indicate if you are experiencing pain in any of these areas and what side of body**

Shoulder Left Right Elbow Left Right

Wrist Left Right Hip Left Right

Knee Left Right Foot Left Right



Please mark the areas on the diagram where you

are experiencing pain.

Please circle and rate the severity of your pain on

the scale below

**Neck Mid Back Low Back**

**1 2 3 4 5 6 7 8 9 10 (Worst)**

**Please circle all that apply to your pain or injuries in the following section:**

**Today I am experiencing pain in my:** Neck Mid Back Low Back

**My pain/ symptoms are**

Getting Better

Getting Worse

Staying the same

**Today I have pain that is**

Achy

Burning

Sharp

Stiff

Throbbing

Shooting

Sore

Other

**My pain or injury is on my**

Left Side

Right Side

Both Sides

**My neck pain travels into my**

Left Shoulder

Right Shoulder

Left Elbow

Right Elbow

Left Hand

Right Hand

Head

No Radiation

**I have Numbness in my**

Left Shoulder

Right Shoulder

Left Elbow

Right Elbow

Left Hand

Right Hand

Head

No Numbness

**I have weakness in my**

Left Shoulder

Right Shoulder

Left Elbow

Right Elbow

Left Hand

Right Hand

Head

No Weakness

**My mid back pain travels into my**

Neck

Shoulders

Chest

Abdomen

Lower Back

Other

**My low back pain travels into my**

Left Buttock

Right Buttock

Left Leg

Right Leg

Left Knee

Right Knee

Left Foot

Right Foot

**I have weakness in my**

Left Leg

Right Leg

Left Knee

Right Knee

Left Foot

Right Foot

No Weakness

**I have numbness in my**

Left Leg

Right Leg

Left Knee

Right Knee

Left Foot

Right Foot

No Numbness

**For Insurance Patients Only**

**The subscribe hereby authorizes his/her insurance company to issue indemnity check to the above listed medical provider for services provided**

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment or any information needed for this of related Medicare claim.

* For an in consideration of services rendered and to be rendered by the listed medical provider, I hereby guarantee payment of all charges incurred for this account.
* The patient or his/her representative recognizing the need for health care, consents to the listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment , laboratory procedures, x-ray examinations or other services rendered under the general and specific instructions of the physicians.
* I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

**Patient Signature** (Parent/ Guardian if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_**