CONFIDENTIAL PATIENT CASE HISTORY INFORMATION

Please fill out this form to the best of your ability. Based upon your answers and our consultation, we will be able to make a decision as to whether or not we will be able to help you. ***We will not accept any patients whom we do not sincerely believe that we can help***……………………..*Thank You*

NAME ________________________ DATE __/__/__ DOB __/__/__ M __ F __

ADDRESS ________________________CITY__________ STATE___ ZIP _______

SS#_________________________ MARITAL STATUS ____ # CHILDREN _____

HOME/WORK/CELL PHONE_____________/______________/_____________

OCCUPATION _________________________ E-MAIL _____________________

Please indicate the letter next to each condition(s) that you have presently ***paying particular attention to the underlined symptoms.***

O – OCCASIONAL F – FREQUENT C – CONSTANT N - NEVER

General	**Muscle/Joint/Nerve**	**Gastro-Intestinal**	**Cardio-Vascular**
Chills ___	Low Back Pain ___ Leg pain ___	Recent Changes **Y N**	High blood pressure ___
Dizziness **Y N**	Hip pain ___	Belching ___	Low blood pressure ___
Drop Attack **Y N**	Knee Pain ___	Gas ___	Irregular heartbeat ___
Fatigue ___	Ankle pain ___	Colitis ___	Swelling of ankles ___
Headache ___	Foot pain ___	Crohn's Disease ___	
Loss of sleep ___	Neck pain ___ Arm pain ___	IBS ___	**Genital-Urinary**
Weight Loss **Y N**	Shoulder pain ___	Diarrhea ___	Recent Changes **Y N**
Depression ___	Elbow pain ___	Constipation ___	Bed wetting ___
Day sweats **Y N**	Wrist pain ___	Bloody stool **Y N**	Blood in urine **Y N**
Night sweats **Y N**	Hand pain ___	Excessive hunger ___	Frequent urination **Y N**
Fever **Y N**	Swollen joints ___	Poor appetite ___	Difficulty urinating **Y N**
Gait Ataxia **Y N**	Numbness **Y N** Location:	Belly distension ___	Painful urination **Y N**
Eyes,Ears,Nose,Throat	**For Woman Only**	Nausea **Y N**	Pus in urine ___
Earache ___	Excess menstrual flow Y N	Vomiting **Y N**	Prostate trouble ___
Enlarged glands ___	Painful menstruation ___	Vomiting of blood ___	
Far sightedness ___	Irregular cycle ___	**Skin**	**Respiratory**
Near sightedness ___	Menopausal symptoms ___	Itching ___	Asthma ___
Nystagmus(eye shake)**Y N**	Hot flashes ___	Dryness ___	Spitting up phlegm ___
Diplopia(dble vision)**Y N**	Vaginal discharge ___	Rash **Y N**	Spitting up blood **Y N**
Visual Disturbance Y N	Are you pregnant? Y N	Bruise easily ___	Wheezing ___
Nosebleeds ___		Varicose veins ____	Chronic cough **Y N**
Dysarthria (speech)**Y N**			
Dysphasia (swallow) **Y N**			

Please circle the following conditions that you have now or have had:

Alcoholism	Diphtheria	HIV/AIDS	Stroke
Anemia	Eczema	Lupus	Ulcers
Arthritis	Emphysema	Measles	Venereal Disease
Cancer	Epilepsy	Mumps	
Chorea	Gout	Polio	
Diabetes	Heart Disease	Scleroderma	

List surgical operations and years: ____
____

Drugs presently taken:
____
____

Birth control pills? Yes No

Do you wear any type of heel lifts and/or arch supports? Yes No

Family Health History

Relation: _________ Condition: ____
Relation: _________ Condition: ____
Relation: _________ Condition: ____

Have you ever:

Been knocked unconscious	Y	N	____
Had a fractured bone	Y	N	____
Hospitalized (not surgery)	Y	N	____
Been in an auto accident	Y	N	____
Had any type of body trauma	Y	N	____

Habits

Alcohol:	Heavy	Moderate	Light	None Type: _____ # cups/day: ____
Coffee:	Heavy	Moderate	Light	None # cups/day: _____
Tobacco:	Heavy	Moderate	Light	None # packs/day: ____
Drugs:	Heavy	Moderate	Light	None
Exercise:	Heavy	Moderate	Light	None Type: ______________________

List below any conditions that you have been treated for which was not mentioned above: