CONFIDENTAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be a part of your permanent file record. Email is Opt-In and used for patient correspondence.

Name ________________________________ Birthday:_________ Sex: M_____ F_____

Address: ______________________________________City:__________Zip:__________

SS# _____-____-_______ Home/Cell Phone__________________ Work Phone _______________

Email: __________________________________ Habits: Alcohol - Drinks/Week ________

Marital Status: M S D W Coffee/Caffeine - Drinks Cups/Day _______

Of Children _______ Ages: ____________________ Smoking - Number of Packs/Day ________

Student: _____Yes _____No If yes, school: ____________________________________

Occupation: ___________________________ Employer: ___________________________________

Spouse's Name _______________________

Reason for Visit________________________ How long have you had this condition? ______

Have you had this or similar conditions in the past? ___________________________________

What do you think caused this condition? _______________________________________

Do any positions make it feel worse? ____

Is this condition: _____ Improved _____ Unchanged _____Getting Worse

Is this condition interfering with your _____ Work _____Sleep _____Daily Routine _____Other

Other therapists or doctors who have treated you for this condition:_______________________

List surgical operation and years: ____

Do you have a current physician/pediatrician __Yes __No If yes: Name ________________

Medications, drugs, dosage and frequency: ____

Have you been in an auto accident or had any other personal injury within 6 months? ___Y___N

Describe____

How did you hear about us? __Health Fair __Search Engine __Doctor Referral___________________

__Website __Letter/Postcard __Outdoor Banner __Other __Friend/Relative_____________________

We like to thank those who refer to us. When YOU refer a friend or family member, what gift would you like to receive? ___ Free Blood Draw ___ Ionic Foot Detox____ $10 Gift Card for Supplements

Signature: ____ Date: ______________________

Parent's Signature (If minor) _______________________________ Date: ______________________