## CONFIDENTIAL CASE HISTORY

| . Have you had a similar problem before? If yes, when? What caused those episodes?  |  |                   | Email     |                         |                    |                                       |  |  |
|---|--|-------------------|-----------|-------------------------|--------------------|---------------------------------------|--|--|
| ddress  | NT   |                   |           | I                       | Home Phone         | 2 Phone                               |  |  |
| te of Birth Age M F Marital Status No. of Children<br>Referred by Please Print PRESENT SYMPTOM: What is your major complaint? MINOR COMPLAINTS: Other areas of pain or concern? When did you first notice major complaint? When did you first notice major complaint? What brought it on? What activities aggravate condition? Is this condition getting progressively worse? Yes No Constant Comes and goes Is this condition interfering with your Work Sleep Daily Routine What do you believe is wrong with you? What have you done to get relief? Has there been a medical diagnosis? If yes, what was the diagnosis? Blood Work Blood Work KST HISTORY Have you had a similar problem before? If yes, when? What caused those episodes? hat relieved them? Hospitalize you? What were the treatments?   | Name   |                   |           | _ `                     | work Phone         |                                       |  |  |
| Referred by   | Address                                      |                   | _ City_   |                         | State              | Zip                                   |  |  |
| Please Print         PRESENT SYMPTOM: What is your major complaint?         MINOR COMPLAINTS: Other areas of pain or concern?         When did you first notice major complaint?         When did you first notice major complaint?         What brought it on?         What scivities aggravate condition?         Is this condition getting progressively worse? Yes         No       Constant         Comes and goes         Is this condition interfering with your         Work       Sleep         Daily Routine         What do you believe is wrong with you?         What have you done to get relief?         Has there been a medical diagnosis?         Blood Work         SST HISTORY         Have you had a similar problem before?       If yes, when?         Have previous diagnosis?       Prevent you from working?         Hospitalize you?       Prevent you from working? |  |                   |           | _ F Mari<br>Referred by | ital Status        | No. of Children                       |  |  |
| PRESENT SYMPTOM: What is your major complaint?         MINOR COMPLAINTS: Other areas of pain or concern?         When did you first notice major complaint?         When did you first notice major complaint?         What brought it on?         What activities aggravate condition?         Is this condition getting progressively worse? Yes         No       Constant         Comes and goes         Is this condition interfering with your         Work       Sleep         Daily Routine         What do you believe is wrong with you?         What have you done to get relief?         Has there been a medical diagnosis?         Blood Work         X-Rays         Blood Work         ST HISTORY         . Have you had a similar problem before?       If yes, when?         What relieved them?  | •  |                   |           | v <u> </u>              |                    |                                       |  |  |
| MINOR COMPLAINTS: Other areas of pain or concern?   |  |                   | Plea      | ase Print               |                    |                                       |  |  |
| When did you first notice major complaint?         What brought it on?         What activities aggravate condition?         Is this condition getting progressively worse? Yes No Constant Comes and goes         Is this condition interfering with your         Work Sleep Daily Routine         What do you believe is wrong with you?         What have you done to get relief?            By whom?            Blood Work         SST HISTORY               If yes, when?            What caused those episodes?  | I. PRESENT SYMPTOM: Wh                       | at is your major  | · complai | nt?                     |                    |                                       |  |  |
| What brought it on?   | 2. MINOR COMPLAINTS: O                       | other areas of pa | in or con | cern?                   |                    |                                       |  |  |
| What activities aggravate condition?  | 3. When did you first notice ma              | jor complaint?    |           |                         |                    |                                       |  |  |
| Is this condition getting progressively worse? Yes No Constant Comes and goes<br>Is this condition interfering with your Work Sleep Daily Routine<br>What do you believe is wrong with you?<br>What have you done to get relief?<br>Has there been a medical diagnosis? If yes, what was the diagnosis?<br>By whom?<br>X-Rays Blood Work<br>SST HISTORY<br>Have you had a similar problem before? If yes, when? What caused those episodes?<br>hat relieved them?<br>d they disable you? Prevent you from working? Hospitalize you?<br>What was the previous diagnosis? What was the treatments?  | 4. What brought it on?                       |                   |           |                         |                    |                                       |  |  |
| Is this condition interfering with your Work Sleep Daily Routine<br>What do you believe is wrong with you?<br>What have you done to get relief?<br>Has there been a medical diagnosis? If yes, what was the diagnosis?<br>By whom? Blood Work<br>X-Rays Blood Work<br>AST HISTORY<br>Have you had a similar problem before? If yes, when? What caused those episodes?<br>hat relieved them?<br>d they disable you? Prevent you from working? Hospitalize you?   | 5. What activities aggravate co              | ndition?          |           |                         |                    |                                       |  |  |
| What do you believe is wrong with you?         What have you done to get relief?         .         Has there been a medical diagnosis?         By whom?         X-Rays         Blood Work         AST HISTORY         .         Have you had a similar problem before?         If yes, when?         What caused those episodes?  | 6. Is this condition getting prog            | ressively worse?  | Yes       | No Co                   | nstant Cor         | nes and goes                          |  |  |
| What have you done to get relief?         . Has there been a medical diagnosis?       If yes, what was the diagnosis?         By whom?       Blood Work         X-Rays       Blood Work         AST HISTORY       Blood Work         AST HISTORY       If yes, when?         hat relieved them?       If yes, when?         What caused those episodes?       If yes, when?         hat relieved them?       What caused those episodes?         hat relieved them?       What relieved them?         What was the previous diagnosis?       What work ing?   | 7. Is this condition interfering <b>v</b>    | vith your         | Work _    | Sleep                   | Daily R            | coutine                               |  |  |
| Has there been a medical diagnosis?       If yes, what was the diagnosis?         By whom?       Blood Work         X-Rays       Blood Work         AST HISTORY       Blood Work         AST HISTORY       If yes, when?         hat relieved them?       If yes, when?         Have you had a similar problem before?       If yes, when?         What caused those episodes?       If yes, when?         hat relieved them?       What caused those episodes?         Mat relieved them?       What relieved them?         Mat was the previous diagnosis?       What working?         What were the treatments?       What were the treatments?  | 3. What do you believe is wrong              | g with you?       |           |                         |                    |                                       |  |  |
| By whom?  | 9. What have you done to get ro              | elief?            |           |                         |                    |                                       |  |  |
| X-Rays Blood Work<br>AST HISTORY . Have you had a similar problem before? If yes, when? What caused those episodes?<br>hat relieved them?<br>d they disable you? Prevent you from working? Hospitalize you?<br>hat was the previous diagnosis? What were the treatments?  | 10. Has there been a medical dia<br>By whom? | gnosis?           | If yes, w |                         |                    |                                       |  |  |
| . Have you had a similar problem before? If yes, when? What caused those episodes?<br>hat relieved them?<br>d they disable you? Prevent you from working? Hospitalize you?<br>hat was the previous diagnosis? What were the treatments?   | X-Rays                                       |                   | Blood W   | /ork                    |                    | · · · · · · · · · · · · · · · · · · · |  |  |
| hat relieved them?  | PAST HISTORY                                 |                   |           |                         |                    |                                       |  |  |
| d they disable you? Prevent you from working? Hospitalize you?<br>hat was the previous diagnosis? What were the treatments?   | 11. Have you had a similar prob              | lem before?       | _ If yes, | when?                   | What cause         | d those episodes?                     |  |  |
| hat was the previous diagnosis? What were the treatments?   | What relieved them?                          |                   |           |                         |                    |                                       |  |  |
| hat was the previous diagnosis? What were the treatments?   | Did they disable you? Pre                    | event you from w  | orking?   | Hospitaliz              | ze you?            | · · · · · · · · · · · · · · · · · · · |  |  |
| Did they help?  | What was the previous diagnosis              | ?                 |           | What we                 | re the treatments' | ?                                     |  |  |
| me of attending physician?  | Name of attending physician?                 |                   |           | Did the                 | у пер:             |                                       |  |  |
| re you on any medications? Please list them   |  |                   |           |                         |                    |                                       |  |  |

| Are you taking any of the following   | ? <u>Have you ever</u>               | Yes No Describe briefly                |  |  |  |  |  |  |
|---|--------------------------------------|--|--|--|--|--|--|--|
| ( )Laxatives ( )Sedatives<br>( )Aspirins / NSAIDS ( )Vitamins<br>( )Sleeping Pills ( )Minerals<br>( )Insulin ( )Herbs |                                      | s?                                     |  |  |  |  |  |  |
| ()Insum ()Iterbs  | Broken any hones?                    | ,                                      |  |  |  |  |  |  |
| Habits     Heavy Moderate Light None       Alcohol     - Broken any bones?  |                                      |  |  |  |  |  |  |  |
| Coffee  | Been in an accident                  | ent?                                   |  |  |  |  |  |  |
| Tea   | If yes, did you rece                 | - If yes, did you receive a whiplash?  |  |  |  |  |  |  |
| Exercise<br>Weekly Sugar Consumption  |                                      |  |  |  |  |  |  |  |
| DO YOU HAVE ANY DIFICULTY   | Y WITH ANY OF THE FOLLOWING          |  |  |  |  |  |  |  |
|   | ()Muscle spasms in neck              | ()Cold sweats                          |  |  |  |  |  |  |
|   | ()Grating in neck                    | ()Liver trouble                        |  |  |  |  |  |  |
|   | () Tightness of shoulder muscles     | ()Gall bladder trouble                 |  |  |  |  |  |  |
|   | ()Neuritis in shoulders and arms     | ()Indigestion                          |  |  |  |  |  |  |
|   | ()Pins and needles in arms and hands |  |  |  |  |  |  |  |
|   | ()Cold hands                         | ()Constipation                         |  |  |  |  |  |  |
|   | ()Chest pains                        | ()Kidney trouble                       |  |  |  |  |  |  |
|   | ()Shortness of breath                | ()Bladder trouble                      |  |  |  |  |  |  |
|   | ( )T.B.                              | ()Diabetes                             |  |  |  |  |  |  |
|   | ()Heart pain                         | ()Cancer                               |  |  |  |  |  |  |
| ()Face flushed  | ()Heart palpitations                 | ()Sleeping problems                    |  |  |  |  |  |  |
| ()Twitching of face   | ()Heart attacks                      | ()Painful joints                       |  |  |  |  |  |  |
| ()Loss Of memory  | ()High blood pressure                | ()Swollen joints                       |  |  |  |  |  |  |
| •   | ( )Low blood pressure                | ()Arthritis                            |  |  |  |  |  |  |
| · · · ·   | ()Anemia                             | ()Slipped disc                         |  |  |  |  |  |  |
| · · ·   | ()Rheumatic fever                    | ()Pinched nerves in back               |  |  |  |  |  |  |
|   | () Nervous stomach                   | ()Pins and needles in legs             |  |  |  |  |  |  |
|   | ()Stomach trouble                    | ()Swollen ankles                       |  |  |  |  |  |  |
|   | ()Ulcers                             | ()Cold feet                            |  |  |  |  |  |  |
|   | ()Nerves and nervousness             | ()Pains in legs and feet               |  |  |  |  |  |  |
|   | ()Inner tension                      | ()) and in regs and rece               |  |  |  |  |  |  |
| ()Lights bother eyes ()Irritability   |                                      |  |  |  |  |  |  |  |
| How many bowel movements daily  | ? D                                  | Do you have a history of constipation? |  |  |  |  |  |  |
| If yes, what have you done to reliev  | e it?                                |  |  |  |  |  |  |  |
|   |                                      | fortable Bedboard                      |  |  |  |  |  |  |
| Do you use a foam pillow?   | Do you sleep on : Sic                | le Back Stomach                        |  |  |  |  |  |  |
| Are you wearing heel lifts?   | Sole lifts? Arc                      | h Supports Inner Soles                 |  |  |  |  |  |  |
|   | Signature<br>Date                    |  |  |  |  |  |  |  |