

CONFIDENTIAL PATIENT CASE HISTORY

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

Name _____ Birthday Sex M F

Address _____ City _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Work _____ Email _____

Marital Status: M D S W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint?

How long have you had this condition? _____

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

Do any positions make it feel worse? _____

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Is this condition: Improved Unchanged Getting Worse

Is this condition interfering with your: Work Sleep Daily Routine Other _____

Other doctors or therapist who have treated THIS condition _____

What do you think cause this condition? _____

List surgical operations and years:

Do you have a family physician? Name _____

Medications, dosage and frequency:

Have you been in an auto accident or had any other personal injury? Y N Describe

Signature Date _____

Parent/Guardian _____ Date _____

Patient Name _____ Number _____ Date _____