

CASE HISTORY

DATE _____

NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

HOME PHONE _____ WORK PHONE _____ MARITAL STATUS _____

SPOUSE'S NAME _____

CHILDREN'S NAMES AND AGES _____

NAME OF EMPLOYER _____ OCCUPATION _____

HOW LONG EMPLOYED _____ WHO REFERRED YOU _____

PLEASE DESCRIBE YOUR MAJOR COMPLAINTS AND SYMPTOMS _____

WERE THEY CAUSED BY A STRAIN? _____ STRESS? _____ FALL? _____ OVERUSE? _____

EXERCISE? _____ WORK RELATED? _____ AUTO ACCIDENT? _____ UNKNOWN? _____

WHEN DID THIS OCCUR? _____ REOCCURRING CONDITION? _____

ANY FAMILY HISTORY OF THIS CONDITION? _____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? _____

M.D. _____ D.O. _____ D.C. _____ NAME OF DOCTOR _____

DIAGNOSIS _____ TREATMENT _____

WERE X-RAYS TAKEN? _____ WHEN? _____ LENGTH OF TIME UNDER HIS/HER CARE? _____

RESULTS _____

WHAT ACCIDENTS/FRACTURES HAVE YOU HAD? (INCLUDE DATES) _____

WHAT MAJOR SURGERY HAVE YOU HAD? (INCLUDE DATES) _____

LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING _____

WITHIN THE LAST 6 MONTHS? _____

