

# Patient Case History Record

Date: \_\_\_\_\_

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***Welcome to our office. Please complete the following information to help us serve you.***

## General Information

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_  
S, M, D, W

## Employment Information

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Spouse's Employer's Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

## Current complaint/Reason for consulting our office

*Please note your primary complaint below. A separate sheet will be supplied for additional symptoms.*

## Onset and course of your current condition

What is your primary symptom, complaint or presenting condition: \_\_\_\_\_

When did your condition first appear: \_\_\_\_\_

What were you doing at the time the condition first appeared: \_\_\_\_\_

Has your condition progressed: \_\_\_\_\_

Has it worsened: \_\_\_\_\_

Has there been additional loss of function: \_\_\_\_\_

Does the pain radiate or travel: \_\_\_\_\_

**Treatment**

What type of treatment has there been: \_\_\_\_\_

What type of home care: \_\_\_\_\_

Has any of this treatment helped and how: \_\_\_\_\_

\_\_\_\_\_

**Pain & Presenting Symptom**

Where does the pain start: \_\_\_\_\_

Describe the pain: \_\_\_\_\_

How often do you have the pain: \_\_\_\_\_

When you have the pain, how long does it last: \_\_\_\_\_

What time of day is the pain better/worse: \_\_\_\_\_

**Aggravating Factors**

*Please describe anything that causes the pain to worsen. This could include certain positions or activities.*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Relieving Factors**

*Please describe anything that helps relieve the pain. This could include certain positions or activities.*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Associated Symptoms**

*Please list any additional symptoms you currently have that may or may not be related to your primary complaint.*

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**System Review**

*Please provide details for any problems in the following areas.*

Eyes: \_\_\_\_\_

Nose: \_\_\_\_\_

Ears: \_\_\_\_\_

Mouth: \_\_\_\_\_

Throat: \_\_\_\_\_

Teeth: \_\_\_\_\_

Skin: \_\_\_\_\_

**Prior Illness, Surgery & Accidents-Circle ALL that apply**

- |           |                     |                    |                      |
|-----------|---------------------|--------------------|----------------------|
| AIDS      | Emphysema           | Kidney Disease     | Psoriasis            |
| Anemia    | Epilepsy            | Low Back Pain      | Rheumatoid Arthritis |
| Arthritis | Goiter              | Lupus Erythamatosi | Scoliosis            |
| Asthma    | Gout                | Migraine Headaches | Stroke               |
| Cancer    | Heart Problems      | Multiple Sclerosis | Thyroid Disease      |
| Diabetes  | High Blood Pressure | Polio              | Tuberculosis         |
| Exzema    | Hypoglycemia        | Prostate Trouble   | Other: _____         |

**Family History**

	N/A	Diabetes	Heart	Kidney	Cancer	Back Problems	Other
Mother:	_____	_____	_____	_____	_____	_____	_____
Father:	_____	_____	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____	_____	_____

Please describe any specifics regarding your family history: \_\_\_\_\_

\_\_\_\_\_

**Social History-Please specify about any personal habits**

Smoking: \_\_\_\_\_ If so, how much per day/week: \_\_\_\_\_  
Chew Tobacco: \_\_\_\_\_ If so, how much per day/week: \_\_\_\_\_  
Coffee/Tea: \_\_\_\_\_ If so, how much per day/week: \_\_\_\_\_  
Alcohol: \_\_\_\_\_ If so, how much per day/week: \_\_\_\_\_  
Soda: \_\_\_\_\_ If so, how much per day/week: \_\_\_\_\_

**Medications, drugs and/or chemicals**

Are you currently on any medications: \_\_\_\_\_

Who is the prescribing physician: \_\_\_\_\_

Do you use recreational drugs: \_\_\_\_\_

Are you taking any other chemicals: \_\_\_\_\_

**Home, Hobby, Recreational & Occupational factors**

*Please tell us about your home conditions, hobbies, work conditions and any recreations you do or did now or prior to your condition*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_