Patient Case History Record

Kyrsalis Health, LLC **Date:___________________**

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.

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Relieving Factors

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

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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 Erythamatosis	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

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