Confidential Patient Case History

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

Name________________________________Birthday______________Sex___________

Address___________________________________City_____________State____Zip____

Soc. Sec.#_________________Home Phone_______________Work________________

Cell________________E-mail____

Marital Status_____________Children, ages_______________Spouse's Name________

Occupation________________________________Employer_______________________

How 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?____

Do any positions make it feel better?____

Is this condition (circle): Improved Unchanged Getting worse

Is this condition interfering with your (circle): work sleep daily routine __________

Other doctors or therapists who have treated THIS condition______________________

____

Do you have a family physician? Name____

Medications, dosage and frequency:____

____

____

Have you ever been in an auto accident or had any other personal injury? Yes No

If yes, describe____

Signature__________________________________ Date__________

Parent/Guardian_____________________________ Date__________

Patient Name________________________