**CASE HISTORY**

**Please fill out this form completely. Please PRINT.**

NAME_____DATE_____BIRTH DATE_____AGE_____
(first) (middle initial) (last)

ADDRESS_____CITY_____STATE____ZIP_____COUNTY_____

TELEPHONE #_____CELL #_____ WORK #_____

E-MAIL ADDRESS _____

MARRIED_____SINGLE_____DIVORCED_____WIDOW(ER)_____NO. OF CHILDREN_____

OCCUPATION_____EMPLOYER_____BUSINESS PHONE_____

NAME OF SPOUSE_____SPOUSE'S EMPLOYER_____PHONE_____

EMERGENCY CONTACT_____PHONE #_____

WHO REFERRED YOU_____

NAME OF PERSON RESPONSIBE FOR PAYMENT_____

**LIST PRIMARY REASON (S) OR CHIEF COMPLAINT (S) FOR SEEING THE DOCTOR:**

1. _____

2. _____

3. _____

4. _____

5. _____

DATE OF LAST PHYSICAL_____DOCTOR SEEN FOR THIS CONDITION_____

OTHER DOCTORS?_____

**PAYMENT IS EXPECTED AT TIME OF VISIT!**

I understand and agree that health and accident insurance policies are and arrangement between and insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

PATIENT SIGNATURE_____DATE_____

GUARDIAN OR SPOUSE'S SIGNATURE_____DATE_____

**PLEASE NOTE: THERE WILL BE A CHARGE FOR MISSING AN APPOINTMENT UNLESS WE ARE NOTIFIED AT LEAST 24 HOURS BEFORE THE APPOINTMENT TIME.**

**Please complete back of form -------->**

**HEALTH QUESTIONNAIRE:**

Please indicate for each of the questions below your experience by use of the following codes: 1—never had; 2—previously had; 3—presently have.

**MUSCULO-SKELETAL SYSTEM**

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

**GENITO-URINARY SYSTEM**

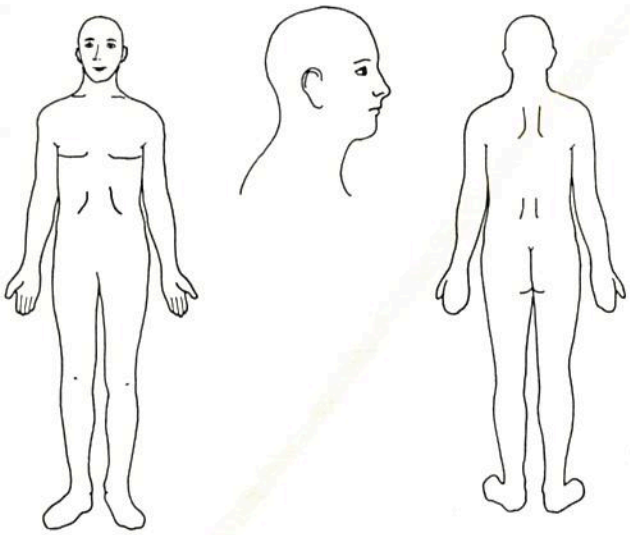
_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

**FEMALE**

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?
_____ Yes _____ No

Please mark your areas of pain on the figures below.



**GASTRO-INTESTINAL SYSTEM**

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

**NERVOUS SYSTEM**

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

**CARDIO-VASCULAR-RESPIRATORY**

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose Veins

**EYE, EAR, NOSE, AND THROAT**

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

_____
Patient's Signature

DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

_____

Patient accepted? Yes_____ No_____ Doctor's signature_____

PATIENT ACKNOWLEDGEMENT

**A copy of the Notice of Privacy Practices is available upon request at your appointment and by subscribing your name below, you acknowledge that you have been given that opportunity and have declined at this time. It is available at any time from our office.**

**Patient's Signature** X _____

**Date** X _____

*FOR PRACTICE USE ONLY*

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

**Patient's acknowledgement of this Notice could not be obtained because:**

- ☐ **Patient refused to sign**
- ☐ **Communication barrier prohibited obtaining acknowledgement**
- ☐ **Emergency circumstances**
- ☐ **Other**

Details:

| |
|---|
| |

_____

**Signature of Practice**

_____

**Date:**

_____

**Patient's Name**