CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Sex: □ M □ F

Address _____ City _____ Zip _____

Soc Sec # _____ E-Mail _____

Home Phone _____ Work _____ Cell _____

Marital Status: □ M □ S □ D □ W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How else 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: □ Improved □ Unchanged □ Getting Worse

Is this condition interfering with your: □ Work □ Sleep □ Daily Routine □ Other _____

Other doctors of therapist who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name _____

Medications, dosage, and frequency: _____

_____

Have you been in an auto accident or had any other personal injury? □ Y □ N

Describe: _____

Signature _____ Date _____

Parent/Guardian _____ Date _____