## Required for Your Case History File - All Information Is Confidential

Full Legal Name	Name you prefer			
Mailing Address	City			
State Zip Code	Home Phone			
□Female □Male Years of education	Work Phone			
Age Date of Birth	Cell Phone			
Occupation	Email			
Employer	_ Work address			
□Single □Married □Widowed □Divorcced	□Separated □Partner Number of Children			
Who referred you to our office?				
Name of Spouse/Partner				
Spouse/Partner Cell #	Spouse/PartnerWork #			
Your Emergency Contact	Phone			
Who is your primary care physician?				
Last Physical Examination Hav	e you been treated for any health condition by a physician in			
the last year? □Yes □No If yes, explain				
Current medications: If not taking any medication	on, check here:			
Current vitamins/herbs/supplements: If not taking	ng any, check here:			
Are you allergic to any medications: □Yes □N	o If yes, list			
Previous serious illness/hospitalization (date and	describe)			

Have you ever had: Surgery/Hospitalization □Yes □No Fractures □Yes □No
Car Accidents □Yes □No Falls □Yes □No On-Job Injury □Yes □No
Describe:
Family history of: Heart disease □Yes □No Cancer □Yes □No Diabetes □Yes □No
Arthritis □Yes □No Back Problems □Yes □No Other
If you are female, are you possibly pregnant? □Yes □No Date of last menstrual period:
Major Symptom/Problem for this visit:
Date symptoms began:
How did your first symptoms first begin:
Other symptoms:
Pain is: □Constant □Intermittent Is your condition getting □worse □better □staying the same
What activities aggravate your condition?
What activities lessen your symptoms?
Is this condition worse during certain times of the day? □Yes □No
Is this condition interfering with work? □Yes □No With sleep? □Yes □No With routine? □Yes □No
Other doctors seen for this condition:
List home remedies tried:

Unexplained weight loss Fatigue or weakness Coughing blood Memory loss Fever Wheczing Tremors Eyes Gastrointestinal Numbness Glaucoma Nausca or vomiting Cataracts Constipation Double vision Double vision Diarrhea Digestive problems Difficulty hearing Dizziness Blood in urine Difficulty sleeping Dizziness Blood in urine Sinus trouble Sinus trouble Difficulty swallowing Dizine wallowing District wallowing Skin Joint stiffness Excessive sweating Rashes Cardiovascular Hives Loss of taste Didestives Chest pain Hematologic/Lymphatic Hematologic/Lymphatic Racing heartbeat Gums bleed easily Hives/hay fever Fainting spells Check if you have had any of the following: Dirison bleed in tolerane Check if you have ever had any of the following: Difficulty surport in the last 30 days: Death of the following: Dirison bleed cash of the following: Dirison bleed cash of the following: Dirison bleed or bladder control Bacterial infection Surgery Fever or chills Check if you have ever had any of the following: Dirison bleed cash of the following: Dirison bleed cash of the following: Dirison bleed cash of the following in the last 30 days: Death of the following: Dirison bleed cash of the following in the last 30 days: Death of the following bleed cash of the following: Dirison bleed cash of the following: Dirison bleed cash of the following in the last 30 days: Death of the following bleed cash of the following	Constitutional	Respiratory	Neurological
Fever	Unexplained weight loss	Cold/flu/cough	Headaches
Fever	Fatigue or weakness	Coughing blood	Memory loss
Glaucoma Nausea or vomiting Loss of strength Cataracts Constipation Seizures Double vision Diarrhea Mental status Ears, nose, throat Digestive problems Anxiety/depression Difficulty hearing Genitourinary Mood swings Buzzing or ringing in ears Blood in urine Difficulty sleeping Dizziness Bladder leakage Stress Loss of smell Burning/frequent urination Endocrine Sinus trouble Musculoskeletal Loss of hair Difficulty swallowing Spinal pain Heat/cold intoleranc Loss of taste Joint swelling Diabetes Skin Joint stiffness Excessive sweating Rashes Cardiovascular Change in appetite Hives Chest pain Hematologic/Lymphatic Itching Shortness of breath Ease of bruising Allergic/Immunologic Racing heartbeat Gums bleed easily Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following:    History of Cancer   History of HIV   Use of Steroids   Use of IV Drugs   Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal or indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal or indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal proper informal proper informal page of the proper informal page of the proper informal page of any informal page of the page of the page of any informal page of the proper informal page of the proper informal page of the proper informal page of the page of the page of the page o		Wheezing	Tremors
Double vision Diarrhea Mental status  Ears, nose, throat Digestive problems Anxiety/depression Difficulty hearing Genitourinary Mood swings Buzzing or ringing in ears Blood in urine Difficulty sleeping Dizziness Bladder leakage Stress Loss of smell Burning/frequent urination Endocrine Sinus trouble Musculoskeletal Loss of hair Difficulty swallowing Spinal pain Heat/cold intoleranc Loss of taste Joint swelling Diabetes Skin Joint stiffness Excessive sweating Rashes Cardiovascular Change in appetite Hives Chest pain Hematologic/Lymphatic Itching Shortness of breath Ease of bruising Allergic/Immunologic Racing heartbeat Gums bleed easily Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following in the last 30 days: □Pain worse at night □Constant pain unrelated to motion □Unexplained weight loss □Loss of bowel or bladder control □Bacterial infection □Surgery □Fever or chills  Check if you have ever had any of the following: □History of Cancer □History of HIV □Use of Steroids □Use of IV Drugs □Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informa	Eyes	Gastrointestinal	Numbness
Double vision	Glaucoma	Nausea or vomiting	Loss of strength
Ears, nose, throat  Digestive problems  Anxiety/depression  Difficulty hearing  Genitourinary  Bood in urine  Difficulty sleeping  Buzzing or ringing in ears  Blood in urine  Difficulty sleeping  Dizziness  Bladder leakage  Stress  Loss of smell  Burning/frequent urination  Sinus trouble  Musculoskeletal  Difficulty swallowing  Spinal pain  Heat/cold intolerane  Loss of hair  Diabetes  Skin  Joint swelling  Diabetes  Skin  Joint stiffness  Excessive sweating  Rashes  Cardiovascular  Change in appetite  Hives  Chest pain  Hematologic/Lymphatic  Itching  Allergic/Immunologic  Racing heartbeat  Gums bleed easily  Hives/hay fever  Fainting spells  Check if you have had any of the following in the last 30 days:  □Pain worse at night  □Constant pain unrelated to motion  □Luexplained weight loss  □Loss of bowel or bladder control  □Bacterial infection  □Surgery  □Fever or chills  Check if you have ever had any of the following:  □History of Cancer  □History of HIV  □Use of Steroids  □Use of IV Drugs  □Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informs	Cataracts	Constipation	Seizures
Difficulty hearing	Double vision	Diarrhea	Mental status
Buzzing or ringing in ears Blood in urine Difficulty sleeping Dizziness Bladder leakage Stress  Loss of smell Burning/frequent urination Endocrine  Sinus trouble Musculoskeletal Loss of hair  Difficulty swallowing Spinal pain Heat/cold intoleranc Loss of taste Joint swelling Diabetes  Skin Joint swelling Diabetes  Skin Joint stiffness Excessive sweating Change in appetite Hives Chest pain Hematologic/Lymphatic Itching Shortness of breath Ease of bruising Allergic/Immunologic Racing heartbeat Gums bleed easily Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following in the last 30 days:  Pain worse at night Constant pain unrelated to motion Unexplained weight loss  Check if you have ever had any of the following:  History of Cancer History of HIV Use of Steroids Use of IV Drugs Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal indepted interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal indepted interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal indepted interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informal indepted interest on indepted interest on indepted i	Ears, nose, throat	Digestive problems	Anxiety/depression
Dizziness Bladder leakage Stress  Loss of smell Burning/frequent urination Endocrine  Sinus trouble Musculoskeletal Loss of hair  Difficulty swallowing Spinal pain Heat/cold intoleranc  Loss of taste Joint swelling Diabetes  Skin Joint stiffness Excessive sweating  Rashes Cardiovascular Change in appetite  Hives Chest pain Hematologic/Lymphatic  Itching Shortness of breath Ease of bruising  Allergic/Immunologic Racing heartbeat Gums bleed easily  Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following in the last 30 days:  □Pain worse at night □Constant pain unrelated to motion □Unexplained weight loss  □Loss of bowel or bladder control □Bacterial infection □Surgery □Fever or chills  Check if you have ever had any of the following:  □History of Cancer □History of HIV □Use of Steroids □Use of IV Drugs □Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informa	Difficulty hearing	Genitourinary	Mood swings
Loss of smell Burning/frequent urination Endocrine  Sinus trouble Musculoskeletal Loss of hair  Difficulty swallowing Spinal pain Heat/cold intoleranc  Loss of taste Joint swelling Diabetes  Skin Joint stiffness Excessive sweating  Rashes Cardiovascular Change in appetite  Hives Chest pain Hematologic/Lymphatic  Itching Shortness of breath Ease of bruising  Allergic/Immunologic Racing heartbeat Gums bleed easily  Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following in the last 30 days:  □Pain worse at night □Constant pain unrelated to motion □Unexplained weight loss  □Loss of bowel or bladder control □Bacterial infection □Surgery □Fever or chills  Check if you have ever had any of the following:  □History of Cancer □History of HIV □Use of Steroids □Use of IV Drugs □Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informa	Buzzing or ringing in ears	Blood in urine	Difficulty sleeping
Sinus trouble Musculoskeletal Loss of hair  Difficulty swallowing Spinal pain Heat/cold intoleranc Loss of taste Joint swelling Diabetes  Skin Joint stiffness Excessive sweating Rashes Cardiovascular Change in appetite Hives Chest pain Hematologic/Lymphatic Itching Shortness of breath Ease of bruising  Allergic/Immunologic Racing heartbeat Gums bleed easily Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following in the last 30 days: Pain worse at night Constant pain unrelated to motion Unexplained weight loss Loss of bowel or bladder control Bacterial infection Surgery Fever or chills  Check if you have ever had any of the following: History of Cancer History of HIV Use of Steroids Use of IV Drugs Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informa	Dizziness	Bladder leakage	Stress
Difficulty swallowing Spinal pain Heat/cold intoleranc Loss of taste Joint swelling Diabetes  Skin Joint stiffness Excessive sweating Change in appetite Hives Chest pain Hematologic/Lymphatic Itching Shortness of breath Ease of bruising Allergic/Immunologic Racing heartbeat Gums bleed easily Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following in the last 30 days:  □Pain worse at night □Constant pain unrelated to motion □Unexplained weight loss □Loss of bowel or bladder control □Bacterial infection □Surgery □Fever or chills  Check if you have ever had any of the following:  □History of Cancer □History of HIV □Use of Steroids □Use of IV Drugs □Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informa	Loss of smell	Burning/frequent urination	Endocrine
Loss of taste  Joint swelling  Joint stiffness  Excessive sweating  Rashes  Cardiovascular  Change in appetite  Hives  Chest pain  Hematologic/Lymphatic  Itching  Shortness of breath  Ease of bruising  Allergic/Immunologic  Racing heartbeat  Gums bleed easily  Hives/hay fever  Fainting spells  Check if you have had any of the following in the last 30 days:  □Pain worse at night  □Constant pain unrelated to motion  □Unexplained weight loss  □Loss of bowel or bladder control  □Bacterial infection  □Surgery  □Fever or chills  Check if you have ever had any of the following:  □History of Cancer  □History of HIV  □Use of Steroids  □Use of IV Drugs  □Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informa	Sinus trouble	Musculoskeletal	Loss of hair
Rashes	Difficulty swallowing	Spinal pain	Heat/cold intolerance
Rashes Cardiovascular Change in appetite Hives Chest pain Hematologic/Lymphatic Itching Shortness of breath Ease of bruising Allergic/Immunologic Racing heartbeat Gums bleed easily Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following in the last 30 days: Pain worse at night Constant pain unrelated to motion Unexplained weight loss Loss of bowel or bladder control Bacterial infection Surgery Fever or chills  Check if you have ever had any of the following: History of Cancer History of HIV Use of Steroids Use of IV Drugs Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informa	Loss of taste	Joint swelling	Diabetes
Hives Chest pain Hematologic/Lymphatic  Itching Shortness of breath Ease of bruising  Allergic/Immunologic Racing heartbeat Gums bleed easily  Hives/hay fever Fainting spells Enlarged glands  Check if you have had any of the following in the last 30 days:  Pain worse at night Constant pain unrelated to motion Unexplained weight loss  Loss of bowel or bladder control Bacterial infection Surgery Fever or chills  Check if you have ever had any of the following:  History of Cancer History of HIV Use of Steroids Use of IV Drugs Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informa	Skin	Joint stiffness	Excessive sweating
Hives	Rashes	Cardiovascular	Change in appetite
Allergic/Immunologic Racing heartbeat Gums bleed easily Hives/hay fever Fainting spells Enlarged glands	Hives	Chest pain	Hematologic/Lymphatic
Hives/hay feverFainting spellsEnlarged glands  Check if you have had any of the following in the last 30 days:  □Pain worse at night □Constant pain unrelated to motion □Unexplained weight loss □Loss of bowel or bladder control □Bacterial infection □Surgery □Fever or chills  Check if you have ever had any of the following: □History of Cancer □History of HIV □Use of Steroids □Use of IV Drugs □Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informatic proceeds.	Itching	Shortness of breath	Ease of bruising
Hives/hay feverFainting spellsEnlarged glands  Check if you have had any of the following in the last 30 days:  □Pain worse at night □Constant pain unrelated to motion □Unexplained weight loss □Loss of bowel or bladder control □Bacterial infection □Surgery □Fever or chills  Check if you have ever had any of the following: □History of Cancer □History of HIV □Use of Steroids □Use of IV Drugs □Blood Transfusions  NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services render I give permission to the clinic to perform necessary tests and treatments.  AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this of does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any informatic proceeds.	Allergic/Immunologic	Racing heartbeat	Gums bleed easily
Check if you have had any of the following in the last 30 days:    Pain worse at night		_	
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	I give permission to the clinic to the clinic to permission to the clinic to the clini	form necessary tests and treatments.  ITH (AUTO/MED PAY) INSURANCE: I aunderstand that I am personally responsible feeds. In the event of my default, I promise to	thorize direct payment from my for any remaining balance this offic o pay legally allowed interest on my
Signature		nce company.	

## FAMILY HEALTH HISTORY

Relation	First Name	Age	State of Health	If Deceased, Cause of Death	Age at Death
Father					
Mother					
Spouse					
Brothers and Sisters  Children  Other					

Patient		Date	
			106