THIS IS A CONFIDENTIAL HEALTH REPORT

NAME_____Date_____
(last) (first) (middle)

HEIGHT_____WEIGHT_____

CHILDREN (list ages & sex)_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

ACCIDENT RELATED | OTHER CAUSES

GENERAL
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Neck Pain
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, numbness or Cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet

GASTRO-INTESTINAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digesting
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear noise
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of the arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inadbility to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstration
- ☐ ☐ Vaginal discharge

Pregnant ☐Yes ☐No
Date of last period_____
Previous miscarriages ☐Yes ☐No

DATE OF LAST: (Approx.)
- _____Physical examination
- _____Blood test
- _____Chest x-ray
- _____Spinal x-ray
- _____Dental x-ray
- _____Urine test

	NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*Please list any prescription drugs now taken, allergies and past surgeries-_____

_____

_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

☐ Aids	☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ Foot Problems	☐ Measles	☐ Polio	☐ Typhoid Fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Ulcers
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Mumps	☐ Scarlet Fever	☐ Venereal Disease
☐ Arteriosclerosis	☐ Emphysema	☐ Heart Disease	☐ Pacemaker	☐ Stroke	

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign your name_____Date_____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

CASE HISTORY