

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME _____ (last) _____ (first) _____ (middle) BIRTH DATE _____ Date _____

HEIGHT _____ WEIGHT _____ SEX _____ Case No. _____

CHILDREN (list ages & sex) _____

Describe major complaints & symptoms (indicate areas of pain on reverse side of this form)

Date you first noticed symptoms _____

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.

OCCASIONAL
FREQUENT

GENERAL

- Allergy (list below)*
- Convulsions
- Dizziness or Fainting
- Headache
- Neuralgia
- Numbness

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Low back pain
- Neck pain or stiffness
- Pain between shoulders
- Sciatica
- Swollen joints
- Pain, numbness or Cramps
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet

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

GASTRO-INTESTINAL

- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Gall bladder trouble
- Hemorrhoids
- Liver trouble
- Pain over stomach

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Deafness
- Earache
- Ear discharge
- Ear noises
- Eye pain
- Nasal obstruction
- Nosebleeds
- Sinus infection

CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow 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
- Inability 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 menstruation
- Vaginal discharge

Pregnant Yes No

Date of last period _____
Previous miscarriages Yes No

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

- | | | | | | |
|---|--------------------------------------|--|---|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke | <input type="checkbox"/> |

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 _____

FEE'S PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

CASE HISTORY