

CASE HISTORY

DATE _____

NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

HOME PHONE _____ WORK PHONE _____ MARITAL STATUS _____

SPOUSE'S NAME _____

CHILDREN'S NAMES AND AGES _____

NAME OF EMPLOYER _____ OCCUPATION _____

HOW LONG EMPLOYED _____ WHO REFERRED YOU _____

PLEASE DESCRIBE YOUR MAJOR COMPLAINTS AND SYMPTOMS _____

WERE THEY CAUSED BY A STRAIN? _____ STRESS? _____ FALL? _____ OVERUSE? _____

EXERCISE? _____ WORK RELATED? _____ AUTO ACCIDENT? _____ UNKNOWN? _____

WHEN DID THIS OCCUR? _____ REOCCURRING CONDITION? _____

ANY FAMILY HISTORY OF THIS CONDITION? _____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? _____

M.D. _____ D.O. _____ D.C. _____ NAME OF DOCTOR _____

DIAGNOSIS _____ TREATMENT _____

WERE X-RAYS TAKEN? _____ WHEN? _____ LENGTH OF TIME UNDER HIS/HER CARE? _____

RESULTS _____

WHAT ACCIDENTS/FRACTURES HAVE YOU HAD? (INCLUDE DATES) _____

WHAT MAJOR SURGERY HAVE YOU HAD? (INCLUDE DATES) _____

LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING _____

WITHIN THE LAST 6 MONTHS? _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect a thorough diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Stroke or family history of |

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Swollen Joints/Stiffness
- Walking Problems
- Difficulty Chewing
- Clicking Jaw

NERVOUS SYSTEM

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY

- Painful/Excessive Urination
- Discolored Urine
- Inability to Control Urination

C-V-R

- Chest Pain
- Irregular Heartbeat
- Cardiovascular Disease
- Varicose Veins
- Ankle Swelling
- High/Low Blood Pressure
- Chronic Coughing
- Difficulty Breathing
- Asthma
- Chronic Congestion

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE / FEMALE

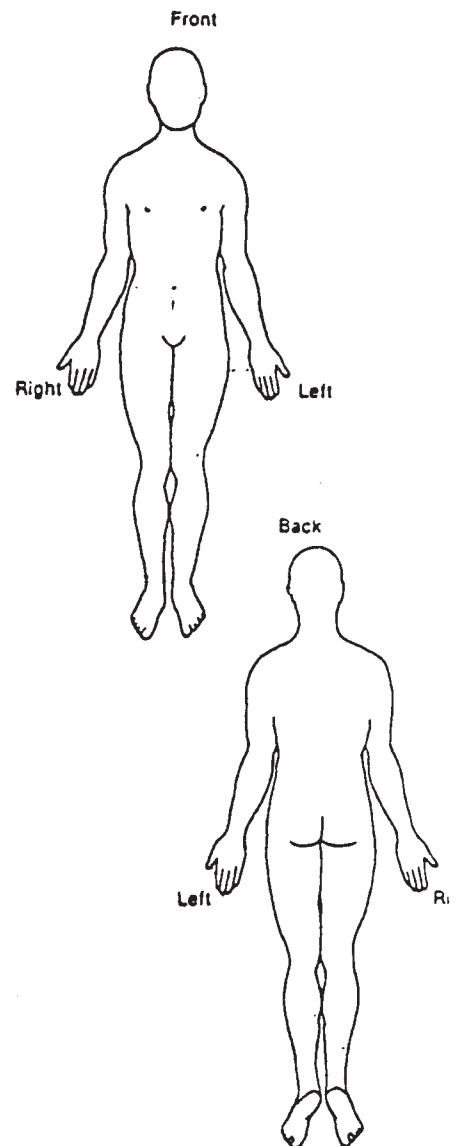
- Taking Oral Contraceptives
- Previous Miscarriage
- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes
- Are You Pregnant? No Yes Maybe
- When Was Your Last Period?

GENERAL

- Allergies
- Sinus Problems
- Loss of Sleep
- Fever
- Bruises Easily

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols.

- | | | |
|---------------------------|-------------------------------|--------------------------|
| Ache
~ ~ ~
~ | Burning
* * * *
* * * * | Numbness
□ □ □ □
□ |
| Pins and Needles
..... | Stabbing
////
//// | Other
====
== |



Patient's Signature _____

Doctor's Signature _____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please notify the Doctor:

- | | | |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of hand grip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do your legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs or feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Do you suffer from headaches, dizziness or memory loss?
Comment: _____ | NO | YES |
| 12. Do you have difficulty maintaining your balance?
Comment: _____ | NO | YES |
| 13. Do you suffer from vertigo or blurred vision?
Comment: _____ | NO | YES |
| 14. Do you suffer from a reduced hearing capacity?
Comment: _____ | NO | YES |
| 15. Do you suffer from ringing in your ears?
Comment: _____ | NO | YES |
| 16. Do you have bladder or bowel control problems on a regular basis?
Comment: _____ | NO | YES |