*Myotherapy* *Nutrition*

*CONFIDENTIAL CASE HISTORY*

Date: _____

**Dear Patient:**
**Please complete front and back of this questionnaire. PLEASE PRINT. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.**

Circle One: Mr., Mrs., Ms., Miss or Dr.
Name: _____ Email: _____
Nickname: _____ Age: _____ Date of Birth: _____

Address: _____ Home phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____

Your Employer: _____ Occupation: _____

Spouse's Name: _____
Employer: _____ Occupation: _____

Nearest Relative not living with you: _____
Address: _____
Referred by: _____

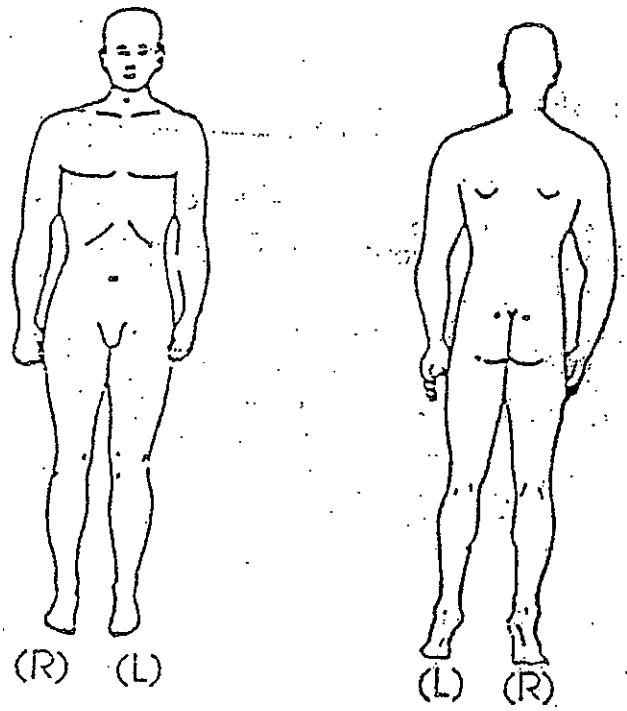
**HEALTH INFORMATION:**
Where were you seen previously? _____
When? _____
Why? _____
Were x-rays or other diagnostic tests taken? _____

**Reasons for consulting our office:**
_____ I have a specific problem and require help only with this problem.
_____ After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.
_____ Once my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
_____ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

**What is your major complaint?** _____
_____
**Other Complaints:** _____
How long have you had this condition?_____ Have you had this or similar condition in the past? _____
What activities aggravated this condition? _____
Is this condition getting progressively worse? _____ Constant _____ Comes and Goes _____
Is this condition interfering with your work? _____ Sleep? _____ Daily Routine? _____ Other: _____
How long since you felt really good? _____
Others who have treated this condition? _____
_____
**List surgical procedures and years performed:** _____
_____
**Drugs you now take:** _____ Nerve Pills _____ Pain Killers _____Muscle relaxants _____ "Pep" Pills _____Tranquillizers
_____ Insulin _____ Birth Control Pills _____ Vitamins _____ Aspirin _____ Others _____
Age of mattress: _____ Comfortable: _____ Uncomfortable: _____
Are you wearing: _____ Heal Lifts _____ Sole Lifts _____ Inner Soles _____ Arch Supports
**Have you been in an auto accident?** _____ Past Year _____ Past 5 Years _____ Over 5 Years _____ Never
Describe: _____
Have you had any *other* personal injury or accident? _____ Past Year _____ Past 5 years _____ Over 5 Years _____ Never

Date of Last Physical Examination_____

Please mark your areas of pain on the figure below.




Have you ever suffered from:

_____ Allergies
_____ Itching
_____ Dizziness
_____ Fatigue
_____ Headaches
_____ Eye Problems
_____ Nose Problems
_____ Ear Problems
_____ Frequent Colds
_____ Chronic Sinus Problems
_____ Stomach or Digestion Problems
_____ Elimination Problems
_____ Heart Problems
_____ Circulation Problem
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Difficulty Breathing
_____ Stroke
_____ Cancer
_____ Urinary Problems
_____ Menstrual Problems
_____ Nervousness/Depression
_____ Arthritis
_____ Neck Pain or Stiffness
_____ Low Back Pain
_____ Foot Trouble
_____ Swollen Joints
_____ Tingling or numbness in

| HABITS: | HEAVY | MODERATE | LIGHT | NONE |
|---|---|---|---|---|
| Alcohol | ------- | ------- | ------- | ------- |
| Coffee | ------- | ------- | ------- | ------- |
| Tobacco | ------- | ------- | ------- | ------- |
| Drugs (Med) | ------- | ------- | ------- | ------- |
| Exercise | ------- | ------- | ------- | ------- |
| Sleep | ------- | ------- | ------- | ------- |
| Appetite | ------- | ------- | ------- | ------- |

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury?_____Yes _____No

Do you have Health Insurance? _____Yes _____No

If yes, Name of Insurance Company_____Policy #_____

Are you covered by Medicare?_____Yes _____No

If yes, Health Insurance #_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermor I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from tl insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account up receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am persona responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional servic rendered me will be immediately due and payable. Payment is expected at the time of visit.

Name of person responsible for payment_____

Patient's Signature_____Date_____

Guardian or Spouse's Signature_____Date_____