CONFIDENTIAL PATIENT CASE HISTORY

NAME: _____ TODAY'S DATE: _____

Birth date: _____ Age: _____ ☐ Male ☐ Female

What brings you here today? _____

How long has it been going on? _____

Last surgical operations and years: _____

Are you wearing ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports ☐ Orthotics

Give your **age at onset** for any of the following conditions you have now or have had.

_____ AIDS	_____ Cancer	_____ Hernia	_____ Pneumonia
_____ Alcoholism	_____ Dislocations	_____ Joint pain	_____ Polio
_____ Appendicitis	_____ Eczema	_____ Hepatitis	_____ Pregnancy
_____ Anemia	_____ Epillepsy	_____ Lumbago	_____ Rheumatic Fever
_____ Arthritis	_____ Goiter	_____ Major grief	_____ Shingles
_____ Bursitis	_____ Heart disease	_____ Neuralgia	_____ Serious falls

Have you suffered from the following?

☐ Loss of Consciousness
☐ Difficulty In Swallowing
☐ Diminished/Partial Loss of Vision In 1 or 2 Eyes
☐ Complete Loss of Vision In 1 or 2 Eyes
☐ Blurred or Double Vision
☐ Hearing Loss In 1 or 2 Ears
☐ Ringing or Buzzing In Ear(s)
☐ Dizziness
☐ History of Neck Sprain Injury
☐ Cervical Spine Spondylosis (Spurring)
☐ Cardiovascular Disease
☐ Family History of Strokes
☐ Slurred/Difficult Speech
☐ Sudden Collapse Without Loss Of Consciousness
☐ Temporary Lack of Understanding
☐ Arteriorsclerosis
☐ Hypertension/High BP
☐ Diabetes

☐ Numbness or Loss of Sensation Anywhere In The Body, Where? _____

HAVE YOU EVER	Yes	No	If so, Please Describe Briefly
Been knocked unconscious?	☐	☐	_____
Had any spinal taps ore spinal injections?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for other than surgery?	☐	☐	_____

HABITS	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

DATE OF LAST	1-6 Mo.	6-18 Mo.	Over 18 Mo.	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

List any accidents or falls and dates: ☐ None ☐ Car _____ ☐ Sports _____ ☐ Recreational _____

Drugs you now take: ☐ Painkillers ☐ Muscle relaxers ☐ Tranquilizers List: _____

Other: _____

Do you suffer from any condition other than that which you are now consulting Pine Tree for? _____

_____

Operations/Procedures & Year

_____ Vaccinations	_____ Breast	_____ Prostate	_____ Gall Bladder
_____ Tonsillectomy	_____ Tubes in Ears	_____ Sinus	_____ Female Organs
_____ Thyroid	_____ Appendectomy	_____ Hernia	_____ Pace Make / Defib
	_____ Back operation	_____ Rectal Surgery	_____ Other: _____