CONFIDENTIAL PATIENT CASE HISTORY

FAX BACK TO: 323-436-0303

(PLEASE PRINT)

NAME ______________________ ☐ FEMALE ☐ MALE DATE __________

WHOM SHOULD WE THANK FOR REFERRING YOU TO US? ______________ AGE _____ BIRTHDAY __________

WHAT IS YOUR JOB OR CAREER? ______________________

WHAT DO YOU LOVE TO DO? FAVORITE HOBBIES OR PASTIMES? ______________________

WHAT IS YOUR CHIEF HEALTH COMPLAINT? ______________________

HOW LONG HAVE YOU HAD IT? _______ HOW IS IT AFFECTING YOUR LIFE? ______________________

IS IT INTERFERING WITH YOUR? ☐ WORK ☐ HOBBIES ☐ SLEEP ☐ DAILY ACTIVITIES ☐ OTHER ACTIVITIES __________

IS IT GETTING? ☐ BETTER ☐ STAYING THE SAME ☐ WORSE HOW LONG HAS IT BEEN SINCE YOU HAVE FELT REALLY GOOD? _______

HAVE YOU SEEN OTHER DOCTORS FOR THIS? ☐ YES ☐ NO WHAT DIAGNOSIS WERE YOU GIVEN? __________

WHAT TREATMENTS HAVE YOU RECEIVED? ______________________

WHAT DO YOU BELIEVE IS WRONG WITH YOU? ______________________

OTHER COMPLAINTS ______________________

____

Have you been in an auto accident or some type of collision? ☐ No ☐ Yes ☐ Recently ☐ Over 1 year ago ☐ Over 5 years ago

Describe Injuries ______________________

Have you had an on-the-job injury? ☐ No ☐ Yes ☐ Recently ☐ Past ______________________

Have you had previous spinal, physical therapy or chiropractic treatment? ☐ No ☐ Yes __________

Do you have recent X-Rays, MRI's or other images of your problem area(s)? ☐ No ☐ Yes __________

Drugs you now take ☐ Anti-Inflammatories ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-Depressants ☐ Tranquilizers ☐ Birth Control Pills

Medication	Condition You Take It For	Medication	Condition You Take It For

Do you take Supplements, Vitamins or Minerals? ☐ Yes ☐ No Multiple? ☐ Yes ☐ No Anti Oxidants? ☐ Yes ☐ No

Other Nutrients You Take ______________________

Would you like help with your supplements and vitamins? ☐ Yes ☐ No Are you allergic to any drug? ☐ Yes ☐ No

Do you exercise: ☐ 0-2 hours per week ☐ 3-5 hours per week ☐ 5 or more hours per week Which drug? __________

Are you? ☐ Content with your weight ☐ Need to lose _____ Pounds ☐ Need to gain

List surgical operations and years ______________________

____

Have you ever:

	No	Yes	Describe Briefly
Been knocked unconscious?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Fractured a bone?	☐	☐	
Had an orthopedic (or neuro) surgery or orthopedic treatment?	☐	☐	
Been hospitalized?	☐	☐	

Habits	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee/Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Sugar/Carb Binging	☐	☐	☐	☐
Drugs	☐	☐	☐	☐

Contact in Case of Emergency:

NAME ______________________

ADDRESS ______________________

PHONE ______________________

(Over)

Conditions for which you have been treated in the past 10 years

FAMILY HEALTH Many health problems have family connections

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

Please check the appropriate box for any of the following symptoms which you now have or previously had:

O = OCCASIONAL F = FREQUENT C = CONSTANT Note that the boxes are marked "O", "F" and "C".

O F C SPINE, ARMS AND LEGS

☐ ☐ ☐ Neck Pain or Stiffness
☐ ☐ ☐ Pain Between Shoulders
☐ ☐ ☐ Low Back Pain
☐ ☐ ☐ Sciatica (Pain Into the Leg)

Pain or Numbness in:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Hands
☐ ☐ ☐ Wrists/Carpal Tunnel
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet

O F C JOINT AND BONE

☐ ☐ ☐ Arthritis/Joint Degeneration
☐ ☐ ☐ Rheumatoid Arthritis
☐ ☐ ☐ Rheumatic Fever
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Gout
☐ ☐ ☐ Muscle Spasms
☐ ☐ ☐ Swollen Joints
☐ ☐ ☐ Hernia
☐ ☐ ☐ Tail Bone Pain
☐ ☐ ☐ Poor Posture
☐ ☐ ☐ Spinal Curvature/Scoliosis
☐ ☐ ☐ Osteoporosis/Weak Bones
☐ ☐ ☐ Polio
☐ ☐ ☐ Multiple Sclerosis

O F C ADRENAL & BLOOD SUGAR

☐ ☐ ☐ Fatigue
☐ ☐ ☐ Headache or Migraine
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Hypoglycemia
☐ ☐ ☐ Diabetes
☐ ☐ ☐ Fainting
☐ ☐ ☐ Nervousness
☐ ☐ ☐ Depression
☐ ☐ ☐ Allergies, Rashes or Hives
☐ ☐ ☐ Inflammatory/Multiple Pain Areas
☐ ☐ ☐ Sleep Problems

O F C GENERAL

☐ ☐ ☐ Thyroid Problems
☐ ☐ ☐ Goiter
☐ ☐ ☐ Other Glandular Problems
☐ ☐ ☐ Chills
☐ ☐ ☐ Sweats
☐ ☐ ☐ Fever
☐ ☐ ☐ Weight Loss
☐ ☐ ☐ Convulsions/Epilepsy
☐ ☐ ☐ Tremors
☐ ☐ ☐ Alcoholism
☐ ☐ ☐ Anemia

O F C GASTRO-INTESTINAL

☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Gas, Burping
☐ ☐ ☐ Colitis/Krohns
☐ ☐ ☐ Colon/Large Intestine Touble
☐ ☐ ☐ Difficult Digestion
☐ ☐ ☐ Burning/Acid Stomach
☐ ☐ ☐ Reflux Disease
☐ ☐ ☐ Hiatal Hernia
☐ ☐ ☐ Pain Over Stomach
☐ ☐ ☐ Ulcers
☐ ☐ ☐ Distension of Abdomen
☐ ☐ ☐ Discomfort After Eating
☐ ☐ ☐ Excessive Hunger
☐ ☐ ☐ Gall Bladder Trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Parasites
☐ ☐ ☐ Liver Disease
☐ ☐ ☐ Nausea
☐ ☐ ☐ Loss of Appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Appendicitis
☐ ☐ ☐ Dysentery
☐ ☐ ☐ Other Digestive Problem

O F C EYES, EARS, NOSE & THROAT

☐ ☐ ☐ Colds
☐ ☐ ☐ Deafness
☐ ☐ ☐ Ear Ache
☐ ☐ ☐ Ear Infections
☐ ☐ ☐ Ear Noises/Tinnitus
☐ ☐ ☐ Eye Pain
☐ ☐ ☐ Loss of Vision
☐ ☐ ☐ Crossed Eyes/Focusing Disorder
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Gum Disease
☐ ☐ ☐ Hay Fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Aggravated Vocal Cords
☐ ☐ ☐ Nasal Obstruction
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus Infections
☐ ☐ ☐ Sore Throat
☐ ☐ ☐ Tonsillitis
☐ ☐ ☐ Pain or Difficulty Swallowing

O F C IMMUNE

☐ ☐ ☐ Weak Immune System
☐ ☐ ☐ Frequent Colds or Flu
☐ ☐ ☐ Herpes/Cold Sores
☐ ☐ ☐ Measles
☐ ☐ ☐ Mumps
☐ ☐ ☐ Veneral Disease
☐ ☐ ☐ Malaria
☐ ☐ ☐ Diptheria
☐ ☐ ☐ Cancer

O F C CARDIOVASCULAR

☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Low Blood Pressure
☐ ☐ ☐ Chest Pain
☐ ☐ ☐ Hardening of Arteries
☐ ☐ ☐ Poor Circulation
☐ ☐ ☐ Rapid or Irregular Heart Beat
☐ ☐ ☐ Slow Heart Beat
☐ ☐ ☐ Ankle Swelling
☐ ☐ ☐ Heart Disease
☐ ☐ ☐ Heart Attack
☐ ☐ ☐ Stroke

O F C RESPIRATORY

☐ ☐ ☐ Difficult Breathing
☐ ☐ ☐ Chronic Cough
☐ ☐ ☐ Mucous/Phlegm
☐ ☐ ☐ Wheezing
☐ ☐ ☐ Asthma
☐ ☐ ☐ Pneumonia
☐ ☐ ☐ Emphysema
☐ ☐ ☐ Tuberculosis
☐ ☐ ☐ Pleurisy

O F C SKIN

☐ ☐ ☐ Itching
☐ ☐ ☐ Hives/Allergy
☐ ☐ ☐ Rash/Eruptions
☐ ☐ ☐ Eczema
☐ ☐ ☐ Acne
☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise Easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Varicose Veins
☐ ☐ ☐ Hair Loss

O F C GENITO-URINARY

☐ ☐ ☐ Frequent Urination
☐ ☐ ☐ Inability to Control Kidneys
☐ ☐ ☐ Kidney Infection or Stones
☐ ☐ ☐ Painful Urination
☐ ☐ ☐ Bed-Wetting
☐ ☐ ☐ Blood in Urine
☐ ☐ ☐ Prostate Trouble
☐ ☐ ☐ Impotence

O F C FOR WOMEN ONLY

☐ ☐ ☐ P.M.S.
☐ ☐ ☐ Menstrual Pain
☐ ☐ ☐ Irregular Menstruation
☐ ☐ ☐ Menopausal Symptoms
☐ ☐ ☐ Hot Flashes
☐ ☐ ☐ Congested/Sore Breasts
☐ ☐ ☐ Vaginal Discharge
☐ ☐ ☐ Other Female Disorder
☐ ☐ ☐ Miscarriage

☐ No ☐ Yes Are You Pregnant?

You can also mail these forms: Universal City Medical Group, Inc. 3535 Cahuenga Blvd. West, Suite #206-208 Los Angeles, CA 90068