

# Confidential Client Case History

## Patient Information

## Phone Numbers

Patient ID: \_\_\_\_\_

Name Mr Mrs Ms Dr Date: \_\_\_\_\_

First/MI/Last \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Sex: ☐ F ☐ M Age \_\_\_\_\_ DOB \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

Learned of us via: \_\_\_\_\_

Phone (H): \_\_\_\_\_

Phone (W): \_\_\_\_\_

Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Name & Address of Health Care Provider you wish report sent to: \_\_\_\_\_

Were you referred by this Provider? Yes \_\_\_\_\_ No \_\_\_\_\_  
(NOTE: In the absence of a complete address, reports will be mailed to the patient for submission to their provider.)

Current Medications	Altern. Therapies	Surgeries/Dates	Location of scars/tattoo's
	Nutritional Supplements		
	Chiropractic / DO		
	Acupuncture / Massage		
	Reiki / PT / Exercise		
	Other		

## Fractures/Injuries:

Smoking Hx:  
Do you smoke? Yes \_\_\_\_\_ Never \_\_\_\_\_ Not in last 12 months \_\_\_\_\_ Not in last 5 years \_\_\_\_\_ Began age \_\_\_\_\_ For # Years \_\_\_\_\_

## Family Health History (Any Cancer/Type; Heart Disease; Diabetes)

Maternal Side Key: M= Mother; S= Sister; B= Brother  
MA/MU= Maternal Aunt/Uncle  
MGM/MGF= Maternal Grandmother/Grandfather

Paternal Side Key: F= Father  
PA/PU = Paternal Aunt/Uncle  
PGM/PGF = Paternal Grandmother/Grandfather

This information is confidential. If information is correct to my knowledge.

Signed \_\_\_\_\_ Date \_\_\_\_\_

For Official Use Only.

Scan Type: \_\_\_\_\_ IM \_\_\_\_\_ C \_\_\_\_\_ DRP \_\_\_\_\_ A \_\_\_\_\_  
Location: \_\_\_\_\_ / \_\_\_\_\_  
Coding: \_\_\_\_\_ Other: \_\_\_\_\_