Special Therapies, Inc.
1720 Dolphin Drive, Unit B
Waukesha, Wisconsin 53186

CONFIDENTIAL CASE HISTORY

We understand this information is personal and confidential.

(Please print)

Name:_____

D.O.B.:_____

Present symptoms (your major complaint):_____

_____

_____

When did you first notice major complaints?_____

Minor complaints (other areas of pain or concern): _____

_____

What brought it on?_____

What activities aggravate the condition?_____

_____

Is this condition interfering with your work:_____sleep_____daily routine? _____

What do you believe is wrong with you?_____

What have you done to get relief?_____

Past History:

Have you had similar problems before?_____If yes, explain: When?_____

What caused the episodes?_____What relieved them?_____

Did they prevent you from working?_____Hospitalize you?_____Disable you?_____

What was the previous diagnosis?_____

What were the treatments?_____

Name the attending physician?_____

How many physicians have treated you for this injury?_____

Are you taking any of the following? Circle all that apply:

Laxatives	Sedatives	Aspirins	Vitamins	Anti-Depressants
Sleeping Pills	Hormones	Insulin	Herbs	Diet Supplements

List medications:_____

Social Habits:

	3-5x's/week Heavy	1-3x's/week Moderate	<1x/week Light	None
Alcohol	_____	_____	_____	_____
Coffee/tea/caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Weekly Sugar intake	_____	_____	_____	_____

Have you ever:

	Yes	No	Describe briefly:
Had any operations?	_____	_____	_____
Broken any bones?	_____	_____	_____
Been in an accident?	_____	_____	_____
Had whiplash?	_____	_____	_____

Do you have any difficulty with the following?

Circle all that apply.

Headaches
Shooting head pains
Sinus trouble
Loss of smell
Hayfever
Asthma
Loss of taste
Tightness in throat
Thyroid trouble
Face flushed
Twitching of face
Loss of memory
Fatigue
Depression
Head feels too heavy
Dizziness
Fainting
Loss of balance
Ringing in ears
Wearing glasses
Lights bother eyes
Irritability
Muscle Spasms in neck
Grating in neck
Tightness of shoulder muscles
Neuritis in shoulders and arms
Pins and needles in arms and legs
Cold hands
Chest pains
Shortness of breath
T.B.
Heart pain
Heart palpitations
Heart attacks
High blood pressure
Low blood pressure
Anemia
Rheumatic fever
Nervous stomach
Stomach trouble
Ulcers
Nerves and nervousness
Inner tension
Cold sweats
Liver trouble
Gall bladder trouble
Indigestion
Intestinal gas
Constipation
Kidney trouble
Bladder trouble
Diabetes
Cancer
Sleeping problems
Painful joints
Swollen joints
Arthritis
Pinched nerves
Pins and needles in leg
Swollen ankles
Cold feet
Pains in legs and feet
Disc herniation
Disc rupture
Slipped/bulging disc

Male Only:

History of prostate trouble
Urination difficult or dribbling
Frequent night urination
Burning upon urination
Pain in the shoulders
Persistent abdominal pain
Pain on outside of legs & heels
Pain in groin area
Sacroiliac or low back pain
Tire easily
Lack energy
Nervousness
Excessive perspiration
Dizziness
Diminished sex drive
Burning or pain during orgasm

Female Only:

Very easily fatigued
Pre-menstrual tension or depression
Painful menstruation cramps
Menstruation excessive or prolonged
Menstruation scanty or missing
Vaginal discharge
Painful breasts
Menopausal hot flashes, etc.
Melancholia of long standing
I.U.D. Diaphragm
Birth control pills
How many pregnancies? ____
Difficult births or pregnancies
How many births? ____
Hysterectomy
Breast implants

Patient Signature:_____

Date:_____