Special Therapies, Inc.

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CONFIDENTIAL CASE HISTORY

Name: _____ Date of Birth: _____

Present symptoms (your major complaint): _____

_____

_____

Date of onset: _____

Minor complaints (other areas of concern): _____

_____

What brought symptoms 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, when? _____

What caused the episodes? _____ What relieved them? _____

_____

Does issue prevent you from working? _____ Hospitalize you? _____ Disable you? _____

Prior diagnoses: _____

Prior treatments for condition: _____

_____

Name of physicians/practitioners who have treated you for this issue: _____

_____

_____

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

Laxatives	Sedatives	Aspirin	Vitamins	Anti-depressants
Sleeping pills	Hormones	Insulin	Herbs	Diet supplements

List medications and supplements:

_____

_____

Please list with dates:

[ ] Prior surgeries_____

_____

[ ] Broken bones_____

[ ] Auto accident_____

[ ] Whiplash_____

Other health history:_____

_____

_____

Social Habits:	3-5x per week **Heavy**	1-3x per week **Moderate**	<1x per week **Light**	**None**
Alcohol	_____	_____	_____	_____
Coffee/tea/caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Weekly sugar intake	_____	_____	_____	_____

Do you have any difficulty with the following?

Circle all that apply:

Headaches
Sinus trouble
Hayfever
Asthma
Thyroid trouble
Fatigue
Fainting
Shortness of breath
Heart pain
Heart palpitations
Heart attack
High blood pressure
Low blood pressure
Kidney trouble
Bladder trouble
Diabetes
Cancer
Swollen ankles

Shooting head pain
Tightness in throat
Twitching of face
Head feels too heavy
Muscle spasms in neck
Grating in neck
Tightness of shoulder muscles
Neuritis in shoulders and arms
Pins and needles in arms
Painful joints
Swollen joints
Arthritis
Pinched nerves
Pins and needles in legs
Pain in legs and feet
Disc herniation/rupture
Slipped/bulging disc

Loss of smell
Loss of taste
Loss of memory
Dizziness
Loss of balance
Ringing in ears
Wearing glasses
Lights bother eyes
Cold hands and feet

Nervous stomach
Stomach trouble
Ulcers
Liver trouble
Gall bladder trouble
Indigestion
Intestinal gas
Constipation

Face flushed
Depression
Inner tension
Irritability
Nervousness
Cold sweats
Sleeping problems

Circle all that apply:

MALE ONLY:

History of prostate trouble
Urination difficulty or dribbling
Frequent night urination
Burning upon urination
Pain in the shoulders
Persistent abdominal pain
Pain on outside of legs/heels
Burning/pain during orgasm

Tire easily
Lack energy
Nervousness
Excessive perspiration
Dizziness
Diminished sex
Pain in groin area
Low back pain

Circle all that apply:

FEMALE ONLY:

Very easily fatigued
Pre-menstrual tension or depression
Painful menstruation cramps
Menstruation excessive or prolonged
Menstruation scanty or missing
Difficult pregnancies/births
Menopausal hot flashes, etc.
Melancholia of long standing

I.U.D. Diaphragm
Birth control pills
Vaginal discharge
Number of pregnancies_____
How many births? _____
Hysterectomy
Painful breasts
Breast implants

Patient signature: _____ Date: _____