

AFFINITY HEALTH & WELLNESS PATIENT CASE HISTORY



Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
Email Address: _____ Occupation: _____
Date of Birth: _____ Social Security #: _____ - _____ - _____ Gender: Male - Female
How did you find out about Affinity: Friend, Doctor, Print Ad, Internet Search, Newsletter, Location, Event
Other or Specific Event: _____
Who may we thank for referring you? _____

List any **Allergies**:

Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen
 Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

List any **Surgeries**:

Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____

List **ALL Past Medical History** conditions:

Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression
 Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain
 Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure
 Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain
 Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's
 Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain
 Stroke/Heart Attack Other: _____

List Type of **Medications** you are taking:

Anxiety Muscle Relaxors Pain Killers Insulin Birth control Cardiovascular Allergy Seizure
 Other: _____

List your **Family History**:

Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition
 High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio
 Prostate Problems Stroke/Heart Attack Other: _____

Have you had any auto or other accidents? No Yes

Describe: _____

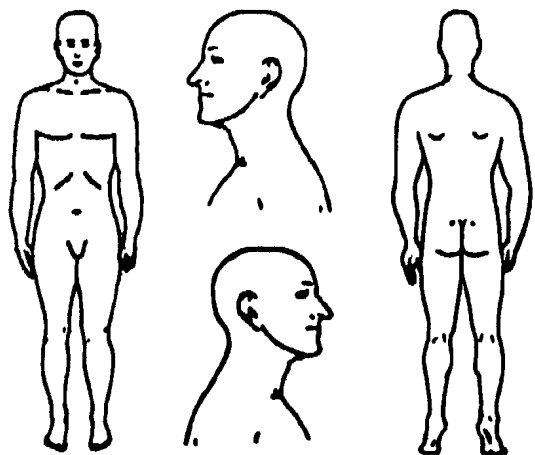
Date of last physical examination: _____ Do you smoke? No Yes

Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level
- Routine Wellness Care

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

- Constantly (76-100% of the day) Frequently (51-75% of the day)
- Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your SECOND complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your next complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____