Confidential Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records.

Thank You.

Name: ………………………………………………………………………. Birthday: …………………………… Sex: ………………

Address: ……………………………………………………………………. City: ………………………………… Zip: ………………..

Home Phone: ………………………………… Work Phone: ……………………….. Email: ………………………………………

Who referred you to us? …………………………………….. How else did you hear about us? ………………………..

What is your major complaints? ……………………………………………………………………………………………………

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How long have you had these conditions? ……………………………………………………………………………………

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Do you have a family physician? Name / Phone #: …………………………………………………………………………

Medications, Natural remedies, Dosage and frequency: …………………………………………………………………

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Signature: ………………………………………………………………………………. Date: ……………………………………………

Parent / Guardian Signature: …………………………………………………. Date: ……………………………………………