CASE HISTORY

1. NAME_____ CELL PHONE_____ PHONE CARRIER_____

2. HOME ADDRESS_____CITY_____

   STATE_____ZIP_____EMAIL_____

3. SOCIAL SECURITY #_____BIRTH DATE_____ AGE_____

4. MARITAL STATUS: ____SINGLE ____MARRIED ____DIVORCED ____SEPARATED ____WIDOW

5. EMPLOYER:_____ OCCUPATION_____

6. DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING DISEASES? (PLACE AN "X" BESIDE THE DISEASE)
   ___HIV+ ___ARTIFICIAL JOINTS ___BURSITIS ___BLOOD CLOTS ___DIABETES ___CANCER
   ___HEPITITIS ___LEUKEMIA ___COLON DISEASE ___MENTAL DISORDER ___EPILEPSY
   ___EMPHYSEMA ___ASTHMA ___GOUT ___GOITER ___ANEMIA ___SEIZURES ___FAINTING SPELLS
   ___HIGH BLOOD PRESSURE ___HERNIA ___HISTORY OF STROKE OR HEART ATTACK
   ___LOW BLOOD SUGAR ___KIDNEY DISEASE ___MULTIPLE SCLEROSIS ___ARTHRITIS
   ___PARKINSON'S DISEASE ___PROSTATE DISEASE ___RUPTURED DISK ___VARICOSE VEINS
   ___RECENT FRACTURES ___OPEN WOUNDS ___RECENT SCARS ___RECENT BRUISES
   ___OTHER:_____ NONE _____

7. DO YOU CURRENTLY HAVE METAL INSERTS (pins/screws) IN YOUR BODY? ___YES ___NO
   IF YES, WHERE? _____

8. IS PREGNANCY CONFIRMED OR SUSPECTED AT THIS TIME? ___YES ___NO. DUE DATE_____

9. DO YOU HAVE HEALTH INSURANCE? ___YES ___NO. NAME OF HEALTH INSURANCE_____

10. PLACE AN (X) BY THE AREAS OF YOUR BODY THAT ARE INJURIED? (Pain scale for doctor's use)

___HEADACHES	___SHOULDER JOINT	___HAND	___LEGS
___JAW	___ARM	___MID BACK	___KNEE
___NECK	___ELBOW	___LOW BACK	___ANKLE
___UPPER BACK	___WRIST	___HIP/BUTTOCKS	___FOOT
___HIT HEAD	___OTHER, DESCRIBE:_____		

11. WHAT IS YOUR HEIGHT? _____ WHAT IS YOUR CURRENT WEIGHT? _____

12. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

    ___STRESS ___DIZZINESS ___INSOMNIA ___FATIGUE ___LOSS OF APPETITE ___FAINTING

    ___LOSS OF MEMORY ___RINGING/BUZZING IN EARS ___PAIN IN OR AROUND THE EYE

    ___POPPING JAW ___LOSS OF TASTE/SMELL ___SORE THROAT ___SHORTNESS OF BREATH

    ___ANXIETY

13. ARE YOU TAKING MEDICATION FOR ANY HEALTH PROBLEMS?
    ___YES ___NO IF YES, DESCRIBE_____

14. HAVE YOU HAD ANY SURGICAL PROCEDURES? ___YES ___NO
    IF YES, WHEN AND DESCRIBE _____

SIGNATURE (X)_____ DATE:_____