

CONFIDENTIAL CASE HISTORY

Title.....SURNAME		NAME	
POSTAL ADDRESS		HOME TEL	
		CELLULAR	
		WORK TEL	
		FAX	
CODE		EMAIL	

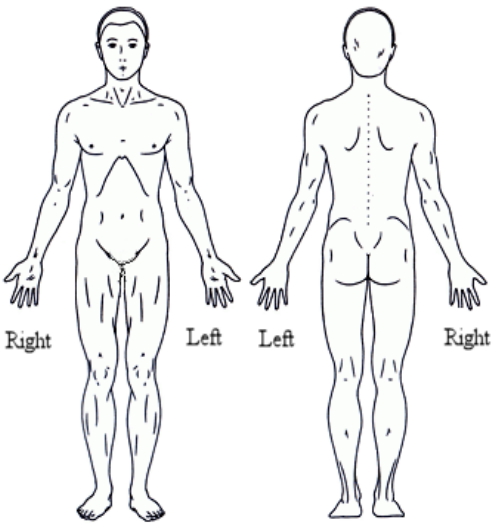
Is you present condition due to an injury?	YES		NO		On the Job		Car accident		Other	
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Referred by:	GP		Family member		Friend		Specialist		Other	
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Name of person who referred you		CONTACT NUMBER	
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General Practitioner		CONTACT NUMBER	

HEALTH REPORT	Reason for seeking care:	
	List any other doctors seen for this:	
	List any diagnosis and type of treatment:	
	Have you ever had similar accidents or injuries?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If YES please explain	

	Please circle degree of pain, 0 none, 10 severe pain.										
	1	2	3	4	5	6	7	8	9	10	
	Using small crosses, mark on the pictures where you feel pain										
	What activities aggravate your condition/pain?										
	What activities lessen your condition/pain?										
	Is this condition worse during certain times of the day?							YES		NO	
	If yes when?										
	Is this condition interfering with;							work?			
	Sleep?			Routine?			Other?				
	Is this condition progressively getting worse?							YES		NO	
List the names of any relatives that have or have had a similar problem:											

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy

MENTAL HEALTH

- Psychological / Emotional
- High stress levels
- Are you often depressed
- Are you often anxious/nervous
- Ever had loss of memory
- Other

FOR WOMEN ONLY

- Birth Control _____
 - Hormone Replacement
 - Cramps/Backaches
 - Excessive Flow
 - Hot Flashes
 - Irregular Cycle
 - Miscarriage
 - Painful Periods
 - Vaginal Discharge
 - Breast Pain
- Pregnant at this Time Y/N

