THIS IS A CONFIDENTIAL HEALTH REPORT

NAME _____ BIRTH DATE _____ Date _____

HEIGHT _____ WEIGHT _____ SEX _____ Case No. _____

CHILDREN (list ages & sex) _____

Describe major complaints & symptoms (indicate areas of pain on reverse side of this form)

_____

Date you first noticed symptoms _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL / FREQUENT

GENERAL
- Allergy (list below)*
- Convulsions
- Dizziness or Fainting
- Headache
- Neuralgia
- Numbness

MUSCLE & JOINT
- Arthritis
- Bursitis
- Foot trouble
- Low back pain
- Neck pain or stiffness
- Pain between shoulders
- Sciatica
- Swollen joints

Pain, Numbness or Cramps
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet

GASTRO-INTESTNAL
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distention of abdomen
- Gall bladder trouble
- Hemorrhoids
- Liver trouble
- Pain over stomach

EYES, EARS, NOSE & THROAT
- Asthma
- Colds
- Deafness
- Earache
- Ear discharge
- Ear noises
- Eye pain
- Nasal obstruction
- Nosebleeds
- Sinus infection

CARDIO-VASCULAR
- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY
- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN
- Bruise easily
- Dryness
- Skin eruptions (rash)
- Varicose veins

GENITO-URINARY
- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

FOR WOMEN ONLY
- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Lumps in breast
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge

Pregnant ☐ Yes ☐ No

Date of last period _____

Previous miscarriages ☐ Yes ☐ No

DATE OF LAST: (Approx.)
- _____ Physical examination
- _____ Blood test
- _____ Chest x-ray
- _____ Spinal x-ray
- _____ Dental x-ray
- _____ Urine test

	NONE	LIGHT	MODERATE	HEAVY
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Soft Drinks				

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*Please list any prescription drugs now taken, allergies and past surgeries - _____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Foot Problems
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Malaria
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign Your Name _____ Date _____

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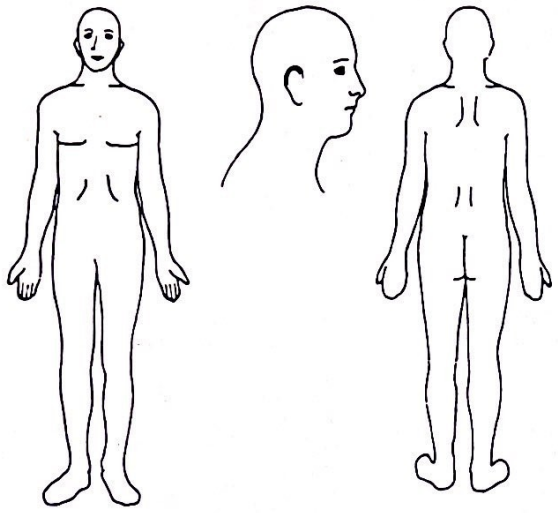
Form C-106 A

CASE HISTORY

Please mark your areas of pain on the figures below.



PATIENTS COMMENTS -

DOCTORS COMMENTS