CONFIDENTIAL PATIENT CASE HISTORY - Dr. Harriet Segelcke, D.C.

HEALTH INFORMATION

Name: ______________________________ Date: __________

Address: ______________________________

City: __________ State: ________ Zip: __________

Home Phone: ____-____-____ Work Phone: ____-____-____ Cell Phone: ____-____-____

Please circle whichever phone you use as your primary phone should we need to reach you.

Email Address: ______________ Occupation: ______________

Date of Birth: __________ Gender: Male - Female

How did you hear about Dr. Segelcke? ______________

What is your major complaint? ______________

How did this problem begin (eg. fall, lifting, etc.)? ______________

How long have you had this condition? ________ Have you had this or similar conditions in the past? ________

What activities aggravate your condition? ______________

What relieves your condition? ______________

Other doctors who treated this condition: ______________

How long has it been since you really felt good? ______________

Other complaints: ______________

List surgical operations and dates: ______________

Drugs you now take: ☐ Nerve pills ☐Muscle relaxers ☐Pain Killers ☐ "Pep" pills ☐Insulin ☐ Tranquilizers ☐Birth control pills ☐others: ______________

Vitamins/Supplements you now take: ______________

Sleeping position: ☐back ☐side ☐stomach Do you wear: ☐Heel lifts ☐Arch supports

Have you ever been in a motor vehicle accident? ☐ No ☐Yes When? ______________

Were you injured? ☐No ☐Yes (describe): ______________

Have you had any other personal injury or accident? ☐ No ☐Yes (when?): ______________

Describe: ______________

Date of last physical examination: ______________

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

Have you in the past or do you presently suffer from
Any of the following?

Y	N		Y	N	
☐	☐	1. Dizziness	☐	☐	8. Neuritis
☐	☐	2. Backaches	☐	☐	9. Digestive Disorders
☐	☐	3. Heart Trouble	☐	☐	10. Nervousness
☐	☐	4. Diabetes	☐	☐	11. Sinus Trouble
☐	☐	5. Arthritis	☐	☐	12. Neck Pain
☐	☐	6. Headaches	☐	☐	13. High Blood Pressure
☐	☐	7. Asthma	☐	☐	14. Painful menstrual cycle
			☐	☐	15. Cancer