



Edwards Holistic Health Center

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Confidential Patient Case History

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Please complete this questionnaire. If the doctor does not feel your condition will respond to her care, she will not accept your case.

NAME _____ DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____
DATE OF BIRTH _____ AGE _____ M _____ F _____ MARITAL STATUS _____ No. of CHILDREN _____
OCCUPATION _____ SS# _____ SPOUSE _____
e-mail: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____

What is your major complaint? _____

How did it happen? _____

Is this an on the job injury? YES NO

Have you missed work from this illness? YES NO Dates missed? _____

Other Complaints: _____

How long have you had this condition? _____ Have you had this before? _____

What activities aggravate your condition? _____

Is this getting progressively worse? YES NO CONSTANT COMES AND GOES

Is this condition interfering with your: WORK SLEEP DAILY ROUTINE OTHER

How long has it been since you really felt well? _____

List previous diagnoses and treatments you have received for your present condition:

What do you believe is wrong with you? _____

List surgical operations and years: _____

Auto Accidents: (when and list injuries) _____

Hospitalizations: (when and why) _____



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NAME _____

Recent dental work? (what and when) _____

Previous Chiropractic Care? (when and where) _____

Have you had x-rays within the last year? _____

Height _____ Weight _____

CIRCLE IF YOU PRESENTLY HAVE OR HAVE HAD:

Dizziness	Nervousness	Foot Problems	Anemia
Low Blood Sugar	Depression	Difficult Digestion	Fainting
Undue Fatigue	Numbness	Enlarged Glands	Alcoholism
Cancer	Painful Tail Bone	High Blood Pressure	Arthritis
Broken Bones	Diabetes	Epilepsy	Asthma

FOR WOMEN ONLY:

Congested Breasts	Excessive Flow	Lumps in Breast	Hot Flashes
Vaginal Discharge	Menopausal Symptoms	Irregular Cycle	Cramps
Painful Menstruation			

Are you pregnant? YES NO

What are the illnesses in your family history? _____

List any and all prescription drugs you are taking: _____

Habits: (times per week)

Alcohol _____

Coffee _____

Tobacco _____

Drugs _____

List all conditions for which you have been
treated in the past 10 years:

Additional information you want the doctor to know about: _____
