Dr. Fran Addeo
13000 US Hwy 1 #3
Sebastian FL 32958
(321) 368-6464

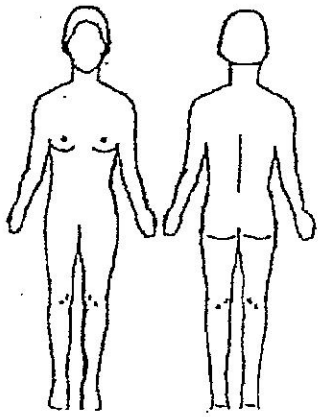
Summer Address: _____ Date: _____
Summer Phone: _____
E-mail: _____

Confidential Case History

Name: _____
Address: _____ Unit #: _____
City: _____ State: _____ Zip: _____
Age: ____ Date of Birth: _____ Sex: ___ Married: ___ S: ___ D: ___ W: ___ Children: _____
Home Phone: _____ Business Phone: _____
Name of Employer: _____ Occupation: _____
Spouse's Name: _____ Spouse's Date of Birth: _____
Spouse's Employer: _____ Occupation: _____
Have you been under Chiropractic care before? Yes: _____ No: _____
If yes, name of D.C.: _____ Date of last visit: _____
Present M.D.: _____ Date of last visit: _____
Reason for coming to us: _____
Who referred you? _____
Date problem began: _____
Is this an injury? Yes: ___ No: ___ Did this occur at work? Yes: __ No: _____
If this is an injury, please state how accident happened.

_____

Have you had any other treatment for this condition? Yes: ___ No:
What type: _____ Doctor: _____ Results: none __ fair ___ good ___

<u>Postural</u> L R  <u>Rom</u> Cerv Comp Shoulder dep Bechterews Kemps <u>Static palp</u>	Mark Area of Pain on The Diagram Below 

List surgeries you have had. Include dates.

List accidents you have had. Include dates.

List medications you are taking, both prescription and over the counter.

List any exercise or sports activities in which you participate.

Do you use any of the following?

_____ tobacco_____alcohol _____ coffee/tea_____cola drinks

Do you wear inserts in your shoes or built up shoes? Yes: ____ No: ____

Please check the following symptoms or conditions you have or have had in the last several years.

GENERAL

( ) Irritability
( ) Fatigue
( ) Depression
( ) Abnormal hair loss or growth
( ) Frequent sinus trouble

HEAD

( ) Headache
( ) Migraine
( ) Tension
( ) Head feels heavy
( ) Loss of memory
( ) Fainting
( ) Loss of smell
( ) Loss of taste
( ) Epileptic seizures
( ) Frequent ear infections
( ) Inner ear trouble
( ) Dizziness
( ) Pain in ears
( ) Ringing in ears
( ) TMJ

EYES

( ) Blinded by lights
( ) Light bothers eyes
( ) Floating spots

NECK

( ) Pain in neck
( ) Stiff neck
( ) Grating or popping sounds in neck

ARMS AND HANDS

( ) Sensation of pins & needles in arms/fingers
( ) Numbness of arms/fingers
( ) Hands cold
( ) Loss of grip strength

LOW BACK

( ) Pain
( ) Stiffness

HIPS, LEGS AND FEET

( ) Pain in hip joint (R-L)
( ) Pain down leg (R-L)
( ) Numbness in leg or feet (R-L)
( ) Pins & needles in legs (R-L)
( ) Feet feel cold
( ) Cramps in feet or legs (R-L)
( ) Swollen ankles (R-L)
( ) Feet tire and ache easily

INTESTINES

( ) Constipation
( ) Diarrhea
( ) Colitis
( ) Distress (nausea) from fatty foods

GASTROINTESTINAL

( ) Burping or bloating
( ) Sour Stomach
( ) Gas
( ) Nausea
( ) Nervous stomach

CARDIOVASCULAR

( ) Low blood pressure
( ) High blood pressure
( ) Pain over heart
( ) Irregular heartbeat
( ) Heart attack

GENITOURINARY

( ) Kidney infection
( ) Inability to control urination
( ) Bladder infections
( ) Need to get up at night to urinate

WOMEN ONLY

( ) Irregular periods
( ) Menstrual cramps
( ) Premenstrual depression
( ) Hysterectomy: __ complete: ____ partial: _____
( ) Miscarriage
( ) Premenstrual breast tenderness
( ) Menopause, date:_____

MEN ONLY

( ) Need to get up at night to urinate
( ) Prostate trouble

Please list any other information that you think we should be aware of in handling your case:

_____

_____

_____

_____

Date:_____ **Patient's Signature:**_____