Benton Family Healthcare LLC
324 S. 25th Street
p: 812.239.2244
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Your Appointment ________________

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records and used to better assess your health. THANK YOU.

Name________________________________D.O.B.__________________________Age____________________Sex [ ] M [ ] F

Address____City/State______________________Zip ____________________

Soc. Sec. #_______-________-________Home Ph.____________________________Cell ___________________________

Email____Marital Status [ ] M [ ] D [ ] S [ ] W

Children? [ ] Yes [ ] No Spouses Name __________________________________

Occupation____________________________________Employer ____

Who referred you to us/ how did you hear about us? ____

What is your major complaint? ____

____

How long have you had this condition? ____

Have you had this or similar conditions in the past? ____

Do any positions make it feel better? ____

Do any positions make it feel worse? ____

Is this condition [ ] Improved [ ] Unchanged [ ] Getting Worse

Is this condition interfering with your [ ] Work [ ] Sleep [ ] Daily Routine [ ] Other: ____

Other therapist who have treated this condition ____

What do you think caused this condition ____

____

Please list any surgical operations and the approximate dates:

____

____

Do you have a family physician? [ ] No [ ] Yes: Name ____

Medications, dosage and frequency: ____

Have you been in an auto accident or had any other personal injuries? [ ] Yes [ ] No

Please explain: ____

____

Signature____Date ___________________________________

Parent/Guardian____Date ___________________________________

Clinical Use Only:

Patient Name__________________Number__________________Date________________________

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REVIEW OF SYSTEMS (CHECK ONES YOU HAVE OR HAD)

GENERAL	NOW	PAST
Weakness	[ ]	[ ]
Fatigue	[ ]	[ ]
Fever	[ ]	[ ]
Chills	[ ]	[ ]
Night Sweats	[ ]	[ ]
Fainting	[ ]	[ ]
SKIN		
Color Changes	[ ]	[ ]
Nail Changes	[ ]	[ ]
Hair Changes	[ ]	[ ]
Moles	[ ]	[ ]
Rashes	[ ]	[ ]
Sores	[ ]	[ ]
Weakness	[ ]	[ ]
HEAD		
Headaches	[ ]	[ ]
Injuries	[ ]	[ ]
Bumps	[ ]	[ ]
Last eye exam	________	
Glasses	[ ]	[ ]
Contacts	[ ]	[ ]
Cataracts	[ ]	[ ]
EARS		
Hard of Hearing	[ ]	[ ]
Deafness	[ ]	[ ]
Ringing	[ ]	[ ]
Discharge	[ ]	[ ]
Earache	[ ]	[ ]
Itching	[ ]	[ ]
Dizziness	[ ]	[ ]
Room Spins	[ ]	[ ]
NOSE		
Decreased Smell	[ ]	[ ]
Bleeding	[ ]	[ ]
Pain	[ ]	[ ]
Discharge	[ ]	[ ]
Obstruction	[ ]	[ ]
Post Naval Drip	[ ]	[ ]
Deviated Septum	[ ]	[ ]
Runny Nose	[ ]	[ ]
Sinus Congestion	[ ]	[ ]
MOUTH		
Bleeding Gums	[ ]	[ ]
Sores	[ ]	[ ]
Dental Problems	[ ]	[ ]
Bad Breath	[ ]	[ ]
Loss of Taste	[ ]	[ ]
Dry Mouth	[ ]	[ ]
Ulcers	[ ]	[ ]
Blisters	[ ]	[ ]

THROAT	NOW	PAST
Soreness	[ ]	[ ]
Bad Tonsils	[ ]	[ ]
Hoarseness	[ ]	[ ]
Pain	[ ]	[ ]
Swallowing	[ ]	[ ]
Infections	[ ]	[ ]
Neck		
Enlarged	[ ]	[ ]
Stiff Neck	[ ]	[ ]
Soreness	[ ]	[ ]
Lumps	[ ]	[ ]
Masses	[ ]	[ ]
Breasts		
Discharge	[ ]	[ ]
Lumps	[ ]	[ ]
Pain	[ ]	[ ]
Bleeding	[ ]	[ ]
Skin change	[ ]	[ ]
Bloated	[ ]	[ ]
LUNGS		
Cough	[ ]	[ ]
Phlegm	[ ]	[ ]
Blood	[ ]	[ ]
Shortness	[ ]	[ ]
Wheezing	[ ]	[ ]
Pain	[ ]	[ ]
Congestion	[ ]	[ ]
Inhalants	[ ]	[ ]
HEART		
Murmur	[ ]	[ ]
Palpitations	[ ]	[ ]
Tachycardia	[ ]	[ ]
Swollen	[ ]	[ ]
Cold Limbs	[ ]	[ ]
Pain	[ ]	[ ]
Pressure	[ ]	[ ]
Varicose	[ ]	[ ]
Blood Clots	[ ]	[ ]
Blue Limbs	[ ]	[ ]
BLOOD		
Anemia	[ ]	[ ]
Low Iron	[ ]	[ ]
Easy Bruising	[ ]	[ ]
Easy Bleeding	[ ]	[ ]
Swollen Nodes	[ ]	[ ]
Painful Nodes	[ ]	[ ]
Red Spots	[ ]	[ ]

DIGESTIVE	NOW	PAST
Abdominal Pain	[ ]	[ ]
Nausea	[ ]	[ ]
Bloated	[ ]	[ ]
Belching	[ ]	[ ]
Heartburn	[ ]	[ ]
Indigestion	[ ]	[ ]
Irregular Bowels	[ ]	[ ]
Constipation	[ ]	[ ]
Diarrhea	[ ]	[ ]
Gas	[ ]	[ ]
Hemorrhoids	[ ]	[ ]
Poor Appetite	[ ]	[ ]
Food Intolerance	[ ]	[ ]
Bloody Stools	[ ]	[ ]
GENITOURINARY		
Urgency	[ ]	[ ]
Incontinence	[ ]	[ ]
Straining	[ ]	[ ]
Back Pain	[ ]	[ ]
FrequentVoiding	[ ]	[ ]
Stones	[ ]	[ ]
Burning	[ ]	[ ]
Bed Wetting	[ ]	[ ]
Small Stream	[ ]	[ ]
Discharge	[ ]	[ ]
Impotence	[ ]	[ ]
Dribbling	[ ]	[ ]
Cloudy Urine	[ ]	[ ]
Urine Color	________	
Cramps	[ ]	[ ]
Discharge	[ ]	[ ]
Itching	[ ]	[ ]
Painful Intercourse	[ ]	[ ]
Irregular Periods	[ ]	[ ]
Hot Flashes	[ ]	[ ]

Contraception Type ____________

Age at first period ____________

Duration of Cycle ____________

No. of Pregnancies ____________

No. of Births ____________

No. of Miscarriages ____________

No. of Abortions ____________

Menstrual Flow [ ] Heavy [ ] Med. [ ]Light

Last Period ____________

Spotting Btwn. Periods

[ ] Now [ ] Past

Clinical Use Only:

Patient Name____________________Number____________________Date______________________

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REVIEW OF SYSTEMS (Continued.)

Neurologic	NOW	PAST
Seizures	[ ]	[ ]
Vertigo	[ ]	[ ]
Hand Trembling	[ ]	[ ]
Loss of Sensation	[ ]	[ ]
Incoordination	[ ]	[ ]
Loss of Facial	[ ]	[ ]
Weak Grip	[ ]	[ ]
Paralysis	[ ]	[ ]
Difficulty Speech	[ ]	[ ]
Tingling	[ ]	[ ]
Loss of Memory	[ ]	[ ]
Numbness	[ ]	[ ]

ENDOCRINE

Weight Loss	[ ]	[ ]
Weight Gain	[ ]	[ ]
Extremely Thin	[ ]	[ ]
Heat Intolerance	[ ]	[ ]
Cold Intolerance	[ ]	[ ]
Hair Changes	[ ]	[ ]
Breast Changes	[ ]	[ ]

PSYCHIATRIC

Hyperventilation	[ ]	[ ]
Insecurity	[ ]	[ ]
Depression	[ ]	[ ]
Troubled Sleep	[ ]	[ ]
Irritable	[ ]	[ ]
Undecidedness	[ ]	[ ]
Timid	[ ]	[ ]
Hallucinations	[ ]	[ ]
Loss of Memory	[ ]	[ ]
Alcoholism	[ ]	[ ]
Drug Addiction	[ ]	[ ]
Drug Dependent	[ ]	[ ]
Suicidal Thoughts	[ ]	[ ]
Extreme Worry	[ ]	[ ]
Sexual Problems	[ ]	[ ]

MUSCULOSKELETAL

Muscle Pain	[ ]	[ ]
Muscle Weakness	[ ]	[ ]
Muscle Cramps	[ ]	[ ]
Muscle Twitching	[ ]	[ ]
Joint Stiffness	[ ]	[ ]
Joint Pain	[ ]	[ ]

PAST MEDICAL HISTORY. CHECK ONLY THE ONES YOU HAVE HAD.

Hay Fever	[ ]	Parasites	[ ]
Mumps	[ ]	Epilepsy	[ ]
Rheumatic Fever	[ ]	Paralysis	[ ]
Allergies	[ ]	Polio	[ ]
Angina	[ ]	Mental Illness	[ ]
Cancer	[ ]	Alcoholism	[ ]
Tumor	[ ]	Depression	[ ]
Blood Disease	[ ]	Nervous Breakdown	[ ]
Leukemia	[ ]	Migraine	[ ]
Heart Trouble	[ ]	Gout	[ ]
Varicose Veins	[ ]	Hemorrhoids	[ ]
Phlebitis	[ ]	Prostate Problems	[ ]
Hypertension	[ ]	Sexual Problems	[ ]
Stroke	[ ]	Gonorrhea	[ ]
Ulcers	[ ]	Syphilis	[ ]
Jaundice	[ ]	Diabetes	[ ]
Skin Trouble	[ ]	Bladder Trouble	[ ]
Gallstones	[ ]	Kidney Stones	[ ]
Liver Trouble	[ ]	Kidney Infection	[ ]
Hepatitis	[ ]	Dysentery	[ ]

ALLERGIES

____

____

____

____

DIABETICS ONLY

When were you diagnosed? ____________________

What is your average blood sugar? ____________________

Would you be interested in nutritional counseling to help control your diabetes? [ ] **Yes** [ ] **No**

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Patient Name____________________Number____________________Date____________________

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FAMILY HISTORY LIST ANY DISEASES WHICH RUN IN YOUR FAMILY

RELATIVE	AGE (LIVING)	AGE (AT DEATH)	CAUSE OF DEATH	ILLNESS
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				
MATERNAL GRANDMOTHER				
MATERNAL GRANDFATHER				
PATERNAL GRANDMOTHER				
PATERNAL GRANDFATHER				

SOCIAL HISTORY (CHECK THE BOXES AND FILL IN)

Height Current Weight_______________________**Have you recently gained weight?** ____________________

Mental Work [ ] Heavy [ ] Moderate [ ] Light Hours Per Day ____________

Physical Work [ ] Heavy [ ] Moderate [ ] Light Hours Per Day ____________

Exercise [ ] Heavy [ ] Moderate [ ] Light Hours Per Day ____________

Smoking [ ] Heavy [ ] Moderate [ ] Light Hours Per Day ____________

Alcohol Beer, Liquor, Wine/ week____________No. of Years ______________

Caffeine (Coffee, Tea, Cola) Cups/Day No. of Years ______________

Aspirin No./ Day__________________________No. of Years______________Other ___________

CIRCLE YOUR LEVEL OF PAIN ON A 1-10 SCALE:

How bad are your symptoms now?

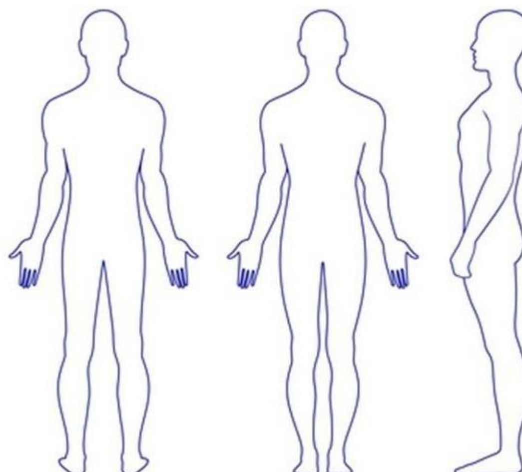
0-----1-----2-----3-----4-----5-----6-----7-----8-----9 ---- 10
None Moderate Severe

How bad have they been in the past?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
None Moderate Severe

MARK THE ARES OF YOUR SYMPTOMS BELOW

Aches: ^^^ Numbness: 000 Pins/ Needles: ... Stabbing: ///



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