



# DR. TAMMY STENBERG, DC

## NEW PATIENT - CONFIDENTIAL CASE HISTORY

HEALING HANDS CHIROPRACTIC AND WELLNESS. 218 SPORTSMAN LN, BIGFORK MT 59911. 406-261-9872

Today's Date:		Policy #			
<b>PATIENT INFORMATION</b>					
Patient's last name:		First:		Middle:	
Marital status:	Children:	Birth date:		Age:	Sex:
Address:					
Email Address:		Home phone no.:		Cell phone no.:	
Occupation:		Employer:		Employer phone no.:	
<b>CURRENT HEALTH</b>					
What is your major complaint?					
How long have you had this condition?		Describe the onset (ie. trauma, events associated):			
Have you had this condition in the past? YES <input type="checkbox"/> NO <input type="checkbox"/> Is this condition getting better or worse?					
What aggravates it?			What helps it?		
How does this condition limit you?					
Has this condition been treated before? YES <input type="checkbox"/> NO <input type="checkbox"/> If so, where?					
In your opinion, what is the cause of this condition?					
Additional health complaints:					
Current medications and supplements:					
<b>IN CASE OF EMERGENCY</b>					
Name of local friend or relative:		Relationship to patient:		Phone no.:	

Patient Name:

DOI

DOB

Policy #



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#### HEALTH HISTORY

Do you have any of the following (Please check all that apply):

AIDS	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	Irritability	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>
Anemia/tiredness	<input type="checkbox"/>	Ear Problems	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Loss of Potency	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Mental Health Disorders	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>
Colds (frequent)	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Urinary tract Infections	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>

List all surgeries (chronologically):

List any hospitalizations:

List all prior fractures/dislocations/concussions:

List all prior accidents (with dates):

List any other back/neck/joint/muscle/tendon/ligament problems:

List all previous illnesses or health problems:

Motor Vehicle Accident or Workman's Compensation (circle): Policy #

Describe incident in detail:



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### FAMILY HISTORY

Have you or anyone in your family had (please check all that apply):

AIDS	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Other:	<input type="checkbox"/>

### REVIEW OF SYSTEMS

Height:                      Weight:                      Weight 1 Year Ago:                      Max weight & when:

Circle **Y** - for condition you have now, **P** - for condition you have had in the past, **N** - for never had

SKIN		EYES		Ears	
Rashes	Y P N	Impaired vision	Y P N	Impaired hearing	Y P N
Eczema	Y P N	Glasses or contacts	Y P N	ringing	Y P N
Acne, boils	Y P N	Tearing or dryness	Y P N	Earache	Y P N
Color changes	Y P N	Double Vision	Y P N	Dizziness	Y P N
Night sweats	Y P N	Glaucoma	Y P N		
		Cataracts	Y P N		

HEAD		MOUTH/THROAT		NOSE/SINUS:	
Headache	Y P N	Frequent sore throat	Y P N	Frequent colds	Y P N
Head Injury	Y P N	Sore tongue	Y P N	Eye Pain	Y P N
		Gum problems	Y P N	Stiffness	Y P N
		Hoarseness	Y P N	Hay Fever	Y P N
		Dental Cavities	Y P N		



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### REVIEW OF SYSTEMS CONT...

NECK		CARDIOVASCULAR		RESPIRATORY	
Lumps	Y P N	Heart disease	Y P N	Headache	Y P N
Swollen glands	Y P N	Angina	Y P N	Head Injury	Y P N
Goiter	Y P N	High Blood pressure	Y P N	Cough	Y P N
Pain or stiffness	Y P N	Murmurs	Y P N	Sputum	Y P N
		Rheumatic fever	Y P N	Coughing up blood	Y P N
<b>GASTROINTESTINAL</b>		Chest Pain	Y P N	Wheezing	Y P N
Trouble swallowing	Y P N	Swelling in ankles	Y P N	Asthma	Y P N
Heart Burn	Y P N	Palpitations (fluttering)	Y P N	Bronchitis	Y P N
Change in thirst	Y P N			Pneumonia	Y P N
Change in appetite	Y P N	<b>URINARY</b>		Pleurisy	Y P N
Nausea	Y P N	Pain on urination	Y P N	Emphysema	Y P N
Nausea vomiting blood	Y P N	Increased frequency	Y P N	Nose bleeds	Y P N
Bowel movements:		Frequency at night	Y P N	Pain on Breathing	Y P N
How often? _____		Inability to hold urine	Y P N	Shortness of breath	Y P N
Is this a change? _____		Frequent infections	Y P N	Tuberculosis	Y P N
Jaundice (yellow skin)	Y P N	Kidney stones	Y P N	Difficulty Breathing	Y P N
Liver disease	Y P N				
Gall bladder disease	Y P N				
Ulcer	Y P N				
Hemorrhoids	Y P N				
Belching or passing gas	Y P N				



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### REVIEW OF SYSTEMS CONT...

FEMALE REPRODUCTIVE		BREASTS		MALE REPRODUCTIVE	
Age menses began? _____		Do you self-exam? Y P N		Hernias Y P N	
Length of cycle? _____		Lumps? Y P N		Testicular masses Y P N	
Bleeding between periods Y P N		Pain (or tenderness) Y P N		Testicular pain Y P N	
Are cycles regular Y P N		Nipple discharge Y P N		Are you sexually active? Y P N	
Pain during intercourse Y P N				Sexual difficulties Y P N	
Painful Menses Y P N		<b>MUSCULOSKELETAL</b>		Prostate disease Y P N	
Excessive Flow Y P N		Joint pain or stiffness Y P N		Venereal disease Y P N	
Birth Control Y P N		Broken bones Y P N		Discharge or sores Y P N	
What type? _____		Weakness Y P N			
# of pregnancy's? _____		Arthritis Y P N		<b>NEUROLOGICAL</b>	
# of abortions? _____				Fainting Y P N	
# of miscarriages? _____		<b>PERIPHERAL VASCULAR</b>		Seizures Y P N	
# of live births? _____		Deep leg pain Y P N		Paralysis Y P N	
Difficulty conceiving Y P N		Cold hands/feet Y P N		Muscle weakness Y P N	
Menopausal Symptoms Y P N		Varicose veins Y P N		Numbness or tingling Y P N	
Are you sexually active Y P N		Thrombophlebitis Y P N		Loss of memory Y P N	
Sexual difficulties Y P N					
Venereal disease Y P N		<b>ENDOCRINE</b>		<b>EMOTIONAL</b>	
		Hypothyroid Y P N		Depression Y P N	
<b>BLOOD</b>		Heat or cold intolerance Y P N		Mood swings Y P N	
Anemia Y P N		Excessive thirst Y P N		Anxiety or nervousness Y P N	
Easy bruising or bleeding Y P N		Excessive hunger Y P N		Tension Y P N	



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REVIEW OF SYSTEMS CONT...			
<b>HABITS</b>			
		Take vacations	Y N
What are your main interests or hobbies?			
		Treated for drug dependence	Y N
Do you exercise?	Y N	Use recreational drugs	Y N
What forms?			
		Use alcoholic beverages	Y N
How often?		Been treated for alcoholism	Y N
Awake rested?	Y N	Use tobacco	Y N
Sleep well?	Y N	Enjoy your work?	Y N
Average 6-8 hrs sleep	Y N	Watch TV?	Y N
		How many hours a day? _____	
Occupation?			
		Read?	Y N
		How many hours a day? _____	

The above information is true to the best of my knowledge.

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Physicians Signature

\_\_\_\_\_  
 Date