DR. TAMMY STENBERG, DC

NEW PATIENT - CONFIDENTIAL CASE HISTORY

HEALING HANDS CHIROPRACTIC AND WELLNESS. 10 SOMERS RD, SOMERS MT 59932. 406-261-9872

Today's Date:	Policy #

PATIENT INFORMATION

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.:

CURRENT HEALTH

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 ☐ NO ☐ 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 ☐ NO ☐ If so, where?

In your opinion, what is the cause of this condition?

Additional health complaints:

Current medications and supplements:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone no.:

Patient Name:	DOI	DOB	Policy #

DR. TAMMY STENBERG, DC

NEW PATIENT CONFIDENTIAL CASE HISTORY

HEALING HANDS CHIROPRACTIC AND WELLNESS. 10 SOMERS RD, SOMERS MT 59932. 406-261-9872

HEALTH HISTORY

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

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

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:

DR. TAMMY STENBERG, DC

NEW PATIENT - CONFIDENTIAL CASE HISTORY

HEALING HANDS CHIROPRACTIC AND WELLNES. 10 SOMERS RD, SOMERS MT 59932. 406-261-9872

FAMILY HISTORY

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

AIDS ☐	Cancer ☐	Kidney disease ☐
Alcoholism ☐	Diabetes ☐	Liver Disease ☐
Arthritis ☐	Gall Bladder Disease ☐	Tuberculosis ☐
Back Problems ☐	Heart disease ☐	Other: ☐

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	Stuffiness	Y P N
		Hoarseness	Y P N	Hay Fever	Y P N
		Dental Cavities	Y P N		

DR. TAMMY STENBERG, DC

NEW PATIENT - CONFIDENTIAL CASE HISTORY

HEALING HANDS CHIROPRACTIC AND WELLNES. 10 SOMERS RD, SOMERS MT 59932. 406-261-9872

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	
GASTROINTESTINAL		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		**URINARY**		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					

DR. TAMMY STENBERG, DC

NEW PATIENT - CONFIDENTIAL CASE HISTORY

HEALING HANDS CHIROPRACTIC AND WELLNES. 10 SOMERS RD, SOMERS MT 59932. 406-261-9872

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	**MUSCULOSKELETAL**		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	**NEUROLOGICAL**	
# of abortions? _____				Fainting	Y P N
# of miscarriages? _____		**PERIPHERAL VASCULAR**		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		Y P N		
Venereal disease	Y P N	**ENDOCRINE**		**EMOTIONAL**	
		Hypothyroid	Y P N	Depression	Y P N
BLOOD		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

DR. TAMMY STENBERG, DC

NEW PATIENT - CONFIDENTIAL CASE HISTORY

HEALING HANDS CHIROPRACTIC AND WELLNES. 10 SOMERS RD, SOMERS MT 59932. 406-261-9872

REVIEW OF SYSTEMS CONT…

HABITS			
		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 _____