



**CONFIDENTIAL CASE HISTORY FORM**

DATE: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_

Who may we thank for sending you here?: \_\_\_\_\_

**\*\*\*At which numbers may we identify ourselves as therapists?\*\*\***

Primary #: ( \_\_\_\_\_ ) \_\_\_\_\_ home work cell

Secondary #: ( \_\_\_\_\_ ) \_\_\_\_\_ home work cell

Other #: ( \_\_\_\_\_ ) \_\_\_\_\_ home work cell

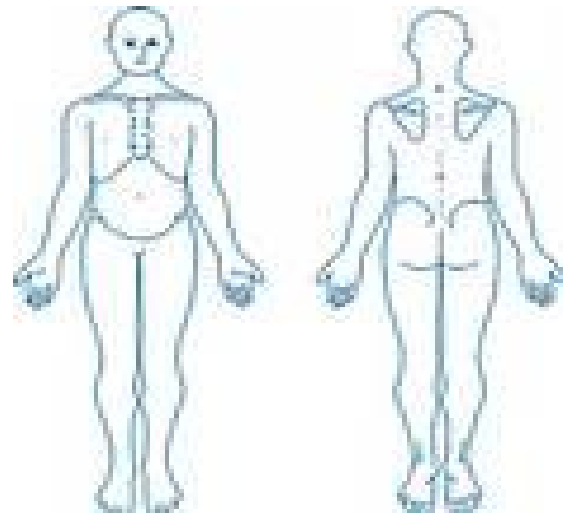
May we email you our Newsletter? Email Address: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Current Medications: \_\_\_\_\_

**Mark the symptoms you have experienced:**

- |                     |               |                    |          |
|---------------------|---------------|--------------------|----------|
| Allergy             | Arthritis     | Asthma             | Bursitis |
| Depression          | Diabetes      | Dizziness          | Fatigue  |
| Headache            | Loss of Sleep | Metal Implants     |          |
| Nervousness         | Numbness      | Tingling Sensation |          |
| High Blood Pressure |               |                    |          |



**Mark areas of discomfort:**

- |           |          |            |       |
|-----------|----------|------------|-------|
| Ankles    | Feet     | Hips       | Knees |
| Low Back  | Mid Back | Upper Back | Neck  |
| Shoulders | Wrists   | Hands      | Jaw   |

Medical History and/or Physical Activities/Sports:

**\*\*\*\* I understand that all appointments at CVWC must be cancelled 24 hours in advance or I will be responsible for the full appointment fee. I also understand that CVWC is aware of my privacy rights and is committed to the responsible handling of my personal information. Sign here: \_\_\_\_\_**