Chagrin Valley Wellness Center

CONFIDENTIAL CASE HISTORY FORM

DATE:_____-_____-_____

Name:_____ **Date of Birth:** _____-_____-_____

Street Address: _____

City:_____ **State:** _____ **Zip Code:** _____

****** Referred By:** _____

Email Address: _____

Primary contact: *use email as primary* **home work cell #: (____)** _____

Secondary: home work cell #: (_____) _____

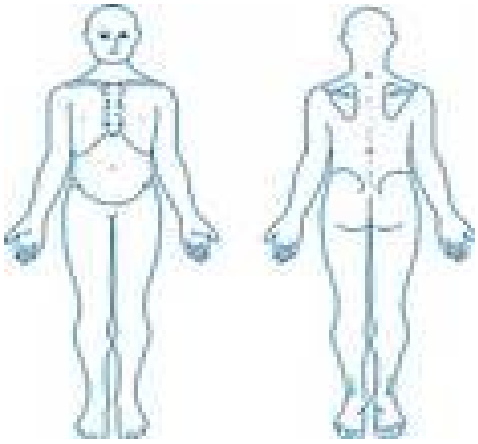
Other: home work cell #: (_____) _____

Reason for Visit: _____

Occupation: _____ **Doctor's Name:** _____

Current Medications: _____

Mark the areas of discomfort below:



Circle 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			

Circle the areas of discomfort:

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

Medical History -- 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: _____

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