



**CONFIDENTIAL CASE HISTORY**

**(PLEASE PRINT LEGIBLY)**

Name: \_\_\_\_\_ Sex: Female or Male Date: \_\_\_\_\_

Street: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: C: (\_\_\_\_) \_\_\_\_\_ H: (\_\_\_\_) \_\_\_\_\_ W: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive our newsletter?  Yes  No

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Blood Type: O A B AB

Marital Status: M D S W

Emergency Contact/ # \_\_\_\_\_

Partner's Name \_\_\_\_\_

Children's' Name/Ages: \_\_\_\_\_

Occupation: \_\_\_\_\_

Occupational Stressors (Chemical, Physical, Structural, Psych): \_\_\_\_\_

List all know Allergies:  
\_\_\_\_\_  
\_\_\_\_\_

Recent Exams (give dates): Physical \_\_\_\_\_ Eye \_\_\_\_\_

Dental \_\_\_\_\_ Ob/Gyn \_\_\_\_\_ Specialist \_\_\_\_\_

Referred to our office by? \_\_\_\_\_

Do you have health insurance?  Yes  No If yes, who is the carrier? \_\_\_\_\_

Please list 5 major health concerns in your order of importance:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Name: \_\_\_\_\_

**List ALL medications (prescriptions and over-the-counter) you take. (Use additional pages if necessary.)**

Name of Prescription/OTC	Dosage	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List ALL nutritional supplements you now take. (Use additional pages if necessary.)**

Name of Supplements	Dosage	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List ALL prior surgeries, hospitalizations, injuries, fractures, dislocations, and illnesses.**

Doctor Name	Date	Treatments / Procedures	Results
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

**Please check all of the following conditions you have experienced in your lifetime.**

- |                                    |                                     |                                       |                                       |  |  |
|------------------------------------|-------------------------------------|---------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Stroke     | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Measles      | <input type="checkbox"/> Kidney infection          | <input type="checkbox"/> Goiter          |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Anemia       | <input type="checkbox"/> Ulcers       | <input type="checkbox"/> ADD/ADHD                  | <input type="checkbox"/> Heart disease   |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> Gout         | <input type="checkbox"/> Depression                | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Thyroid disease           | <input type="checkbox"/> Parkinson's     |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Allergies  | <input type="checkbox"/> Alzheimer's  | <input type="checkbox"/> MS           | <input type="checkbox"/> Gall Bladder Inflammation |  |

**Please check all of the following conditions your family has experienced.**

- |                         |                                 |                                 |  |                                   |                                      |                                      |                             |
|-------------------------|---------------------------------|---------------------------------|--|-----------------------------------|--------------------------------------|--------------------------------------|-----------------------------|
| <b>Father:</b>          | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> MS |
| <b>Mother:</b>          | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> MS |
| <b>Sisters:</b>         | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> MS |
| <b>Brothers:</b>        | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> MS |
| <b>Grandmother (M):</b> | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> MS |
| <b>Grandfather (M):</b> | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> MS |
| <b>Grandmother (P):</b> | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> MS |
| <b>Grandfather (P):</b> | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> MS |

**List any other health concerns not listed:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Please circle the appropriate number "0-3" on all questions below. 0 as the least/never to 3 as the most/always.

**Category I : Colon**

Feeling that bowels do not empty completely 0 1 2 3  
Lower abdominal pain relief by passing stool or gas 0 1 2 3  
Alternating constipation and diarrhea 0 1 2 3  
Diarrhea 0 1 2 3  
Constipation 0 1 2 3  
Hard dry or small stool 0 1 2 3  
Coated tongue of "fuzzy" debris on tongue 0 1 2 3  
Pass large amount of foul smelling gas 0 1 2 3  
More than 3 bowel movements daily 0 1 2 3  
Do you use laxatives frequently 0 1 2 3

**Category II : Hypochloridia**

Excessive belching burping or bloating 0 1 2 3  
Gas immediately following a meal 0 1 2 3  
Offensive breath 0 1 2 3  
Difficult bowel movements 0 1 2 3  
Sense of fullness during and after meals 0 1 2 3  
Difficulty digesting fruits and vegetables; undigested foods found in stools 0 1 2 3

**Category III : Hyperacidity (Ulcer)**

Stomach pain, burning or aching 1-4 hrs. after eating 0 1 2 3  
Do you frequently use antacids 0 1 2 3  
Feeling hungry an hour or two after eating 0 1 2 3  
Heartburn when lying down or bending forward 0 1 2 3  
Temporary relief from antacids, food, milk, soda 0 1 2 3  
Digestive problems subside with rest and relaxation 0 1 2 3  
Heartburn due to spicy foods, chocolate, citrus, Peppers, alcohol and caffeine 0 1 2 3

**Category IV : Small Intestine (Pancreas)**

Roughage and fiber causes constipation 0 1 2 3  
Indigestion and fullness lasts 2-4 hours after eating 0 1 2 3  
Pain, tenderness, soreness on left side under rib cage 0 1 2 3  
Excessive passage of gas 0 1 2 3  
Nausea and/or vomiting 0 1 2 3  
Stool undigested, foul smelling, mucous-like, greasy or poorly formed 0 1 2 3  
Frequent urination 0 1 2 3  
Increased thirst and appetite 0 1 2 3  
Difficulty losing weight 0 1 2 3

**Category V : Biliary Insufficiency/Stasis**

Greasy or high fat foods cause distress 0 1 2 3  
Lower bowel gas and or bloating several hours after eating 0 1 2 3  
Bitter metallic taste in mouth, especially in the Morning 0 1 2 3  
Unexplained itchy skin 0 1 2 3  
Yellowish cast to eyes 0 1 2 3  
Stool color alternates from clay colored brown 0 1 2 3  
Dry or flaky skin and/or hair 0 1 2 3

Reddened skin, especially palms 0 1 2 3  
History of gallbladder attacks or stones 0 1 2 3  
Have you had your gallbladder removed? Yes No

**Category VI : Hypoglycemia**

Crave sweets during the day 0 1 2 3  
Irritable if meals are missed 0 1 2 3  
Depend on coffee to keep yourself going or to get started 0 1 2 3  
Get lightheaded or dizzy if meals are missed 0 1 2 3  
Eating relieves fatigue 0 1 2 3  
Feel shaky, jittery, tremors 0 1 2 3  
Agitated, easily upset, nervous between meals 0 1 2 3  
Poor memory, forgetful 0 1 2 3  
Blurred vision 0 1 2 3  
Difficulty eating in the morning, absent appetite 0 1 2 3

**Category VII : Insulin Resistance**

Fatigue after meals 0 1 2 3  
Crave sweets during the day 0 1 2 3  
Eating sweets does not relieve cravings for Sugar 0 1 2 3  
Must have sweets after meals 0 1 2 3  
Waist girth is equal or larger than hip girth 0 1 2 3  
Frequent urination 0 1 2 3  
Increased thirst & appetite 0 1 2 3  
Difficulty losing weight 0 1 2 3

**Category VIII : Adrenal Hypofunction**

Cannot stay asleep 0 1 2 3  
Perspire easily 0 1 2 3  
Under high amounts of stress 0 1 2 3  
Weight gain when under stress 0 1 2 3  
Wake up tired even after 6 or more hours of sleep 0 1 2 3  
Excessive perspiration or perspiration with little or no activity 0 1 2 3

**Category X : Hypothyroid**

Tired, sluggish 0 1 2 3  
Feel cold – hands, feet, all over 0 1 2 3  
Require excessive amounts of sleep to function properly 0 1 2 3  
Increase in weight gain even with low calorie diet 0 1 2 3  
Gain weight easily 0 1 2 3  
Difficult, infrequent bowel movements 0 1 2 3  
Depression, lack of motivation 0 1 2 3  
Morning headaches that wear off as the day progresses 0 1 2 3  
Outer third of eyebrow thins 0 1 2 3  
Thinning of hair on scalp, face or genitals or excessive falling out of hair 0 1 2 3  
Dryness of skin and/or scalp 0 1 2 3  
Mental sluggishness 0 1 2 3

**Category XI : Pituitary Hypofunction**

Diminished Sex Drive 0 1 2 3  
Menstrual disorders or lack of menstruation 0 1 2 3  
Increased ability to eat sugars without symptoms 0 1 2 3

Name: \_\_\_\_\_

**Category XII: Pituitary Hyperfunction**

Increased sex drive 0 1 2 3  
Tolerance to sugars reduced 0 1 2 3  
"Splitting" type headaches 0 1 2 3

**Category XIII: Thyroid Hyperfunction**

Heart palpitations 0 1 2 3  
Inward trembling 0 1 2 3  
Increased pulse even at rest 0 1 2 3  
Nervous and emotional 0 1 2 3  
Insomnia 0 1 2 3  
In Night Sweats 0 1 2 3  
Difficulty gaining weight 0 1 2 3

**Category XVI (Male Only): Prostrate**

Urination difficulty or dribbling 0 1 2 3  
Urination frequent 0 1 2 3  
Pain inside of legs or heels 0 1 2 3  
Feeling of incomplete bowel evacuation 0 1 2 3  
Leg nervousness at night 0 1 2 3

**Category XV (Males Only): Andropause**

Decrease in libido 0 1 2 3  
Decrease in spontaneous morning erections 0 1 2 3  
Decrease in fullness of erections 0 1 2 3  
Difficulty in maintaining erections 0 1 2 3  
Spells of mental fatigue 0 1 2 3  
Inability to concentrate 0 1 2 3  
Episodes of depression 0 1 2 3  
Muscle Soreness 0 1 2 3  
Decreased in physical stamina 0 1 2 3  
Unexplained weight gain 0 1 2 3  
Increased in fat distribution around chest and hips 0 1 2 3  
Sweating attacks 0 1 2 3  
More emotional than in the past 0 1 2 3

**Category XVI (Menstruating Females Only)**

Are you menopausal? 0 1 2 3  
Alternating menstrual cycle lengths 0 1 2 3  
Menstrual cycle, greater than 32 days 0 1 2 3  
Shortened menses, less than every 24 days 0 1 2 3  
Pain and cramping during periods 0 1 2 3  
Scanty blood flow 0 1 2 3  
Heavy blood flow 0 1 2 3  
Breast pain and swelling during menses 0 1 2 3  
Hair loss/thinning 0 1 2 3  
Facial hair growth 0 1 2 3  
Irritable and depressed during menses 0 1 2 3  
Acne break outs 0 1 2 3  
Pelvic pain during menses 0 1 2 3  
Irritable and depressed during menses 0 1 2 3  
Acne hair growth 0 1 2 3  
Hair loss/ thinning 0 1 2 3  
Date of last menstrual Period \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Currently Pregnant  Yes  No

**Category XVII (Menopausal Females Only)**

How many years have you been menopausal? 0 1 2 3  
Do you ever have uterine bleeding since Menopause? 0 1 2 3  
Hot flashes 0 1 2 3  
Mental foginess 0 1 2 3  
Disinterest in sex 0 1 2 3  
Mood swings 0 1 2 3  
Depression 0 1 2 3  
Painful intercourse 0 1 2 3  
Shrinking breasts 0 1 2 3  
Facial hair growth 0 1 2 3  
Acne 0 1 2 3  
Increased vaginal pain, dryness or itching 0 1 2 3

Dietary Habits: List typical examples of daily meals (use N/A if you usually skip that meal)

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

3 Worst foods you eat during the average week: \_\_\_\_\_

3 Healthiest foods you eat during the average week: \_\_\_\_\_

Exercise type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Daily # of Vegetables: \_\_\_\_\_

Daily # of Fruits: \_\_\_\_\_

Daily # of Caffeinated Beverages: \_\_\_\_\_

# Times per week you eat raw nuts or seeds \_\_\_\_\_

# Times per week you eat fish \_\_\_\_\_

# Times per week you eat out \_\_\_\_\_

Cravings for salt/ sweet/ fats \_\_\_\_\_

Fruit juices oz/ week \_\_\_\_\_

Gatorade oz/ week \_\_\_\_\_

Energy drinks oz/ week \_\_\_\_\_

Chocolate  Dark  Milk

Alcohol drinks/ wk \_\_\_\_\_

Nutritional shakes \_\_\_\_\_

Nutritional bars \_\_\_\_\_

Protein powders \_\_\_\_\_

Meat protein \_\_\_\_\_

Veggie protein \_\_\_\_\_

Milk, oz/ week \_\_\_\_\_

Dairy, kind \_\_\_\_\_

Name: \_\_\_\_\_

Please circle the appropriate number "0-3" on all questions below. 0 as the least/never to 3 as the most/always.

**Section A**

Memory is noticeably declining	0	1	2	3
Having a hard time remembering names and phone numbers	0	1	2	3
Ability to focus is noticeably declining	0	1	2	3
It has become harder to learn things	0	1	2	3
Feelings of hopelessness	0	1	2	3
You have a hard time remembering your appointments	0	1	2	3
Your temperament is getting worse in general	0	1	2	3
Losing your attention span endurance	0	1	2	3
Feeling down or sad	0	1	2	3
Fatigue when driving compared to the past	0	1	2	3
Fatigue when reading compared to the past	0	1	2	3
Walk into rooms and forget why	0	1	2	3
Pick up your cell phone and forget why	0	1	2	3

**Section 1: Serotonin**

Losing your pleasure in hobbies and interest	0	1	2	3
Feel overwhelmed with ideas to manage	0	1	2	3
Feelings of inner rage (anger)	0	1	2	3
Feelings of paranoia	0	1	2	3
Feel sad or down for no reason	0	1	2	3
Feel like you are not enjoying life	0	1	2	3
Feel lack of artistic appreciation	0	1	2	3
Feel depressed in overcast weather	0	1	2	3
Losing enthusiasm for your favorite	0	1	2	3
Losing enjoyment for your favorite foods	0	1	2	3
Losing enjoyment of friendships and relationships	0	1	2	3
Difficulty falling into deep restful sleep	0	1	2	3
Feelings of dependency on others	0	1	2	3
Feel more susceptible to pain	0	1	2	3
Feelings of unprovoked anger	0	1	2	3
Losing interest in life	0	1	2	3

**Section: 2 Dopamine**

Feelings of hopelessness	0	1	2	3
Self-destructive thoughts	0	1	2	3
Inability to handle stress	0	1	2	3
Anger and aggression while under stress	0	1	2	3
Not rested even after long hours of sleep	0	1	2	3
Prefer to isolate yourself from others	0	1	2	3
Unexplained lack of concern for family and friends	0	1	2	3
Inability to finish tasks	0	1	2	3
Need to consume caffeine to stay alert	0	1	2	3
Decreased libido	0	1	2	3
Lose your temper for minor reasons	0	1	2	3
Feelings of worthlessness	0	1	2	3

**Section 3: GABA**

Anxiety or panic for no reason	0	1	2	3
Feelings of dread or impending doom	0	1	2	3
Feelings of being overwhelmed for no reason	0	1	2	3
Feelings of guilt about everyday decisions	0	1	2	3
Feel lack of artistic appreciation	0	1	2	3
Mind feels restless	0	1	2	3
Feel depressed in overcast weather	0	1	2	3
You want to relax	0	1	2	3
Disorganized attention	0	1	2	3
Worry about things you were not worried about before	0	1	2	3
Feelings of inner tension and inner	0	1	2	3

**Section 4: ACH**

Visual memory is decreased	0	1	2	3
Verbal memory is decreased	0	1	2	3
Memory lapses	0	1	2	3
Creativity has been decreased	0	1	2	3
Comprehension had been diminished	0	1	2	3
Difficulty calculating numbers	0	1	2	3
Difficulty recognizing objects & faces	0	1	2	3
Feel like your opinion about yourself has changed	0	1	2	3
Experiencing excessive urination	0	1	2	3
Experiencing slower mental response	0	1	2	3

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please answer all questions as completely and thoroughly as you can. Though some questions may not seem to pertain, they all are very important to help diagnosis and formulate a treatment plan specifically for you and make proper referrals. If needed, list number, then use spaces or back of page to explain more detail.**

**For Medical History:** Current = C Past = P (greater than 6 months) include dates if possible for both

## Healthcare

### Independent or Concurrent Therapies:

- |                               |                            |                          |
|-------------------------------|----------------------------|--------------------------|
| 1. ___ Chiropractic           | 5. ___ Naturopathic        | 9. ___ Specialist        |
| 2. ___ Chiro for family, pets | 6. ___ Oriental Medicine   | 10. ___ Natural Healer   |
| 3. ___ Acupuncture            | 7. ___ Nutritional Consult | 11. ___ Spiritual Healer |
| 4. ___ Therapeutic Massage    | 8. ___ Medical Treatment   | 12. ___ Energy Work      |
- 
- 
- 

**Diagnostic or Routine Exams:** Please list area, Dr. and reason ordered, date and location of exam if known.

- |                    |                        |                     |
|--------------------|------------------------|---------------------|
| 13. ___ X-rays     | 18. ___ Upper/lower GI | 23. ___ Dental Exam |
| 14. ___ MRI        | 19. ___ DEXA Scan      | 24. ___ Colonoscopy |
| 15. ___ CAT Scan   | 20. ___ Breast Exam    | 25. ___ Other _____ |
| 16. ___ Blood draw | 21. ___ Prostate Exam  | 26. ___ Other _____ |
| 17. ___ Ultrasound | 22. ___ Eye Exam       | 27. ___ Other _____ |
- 
- 
- 

### Significant Illnesses

- |                    |                             |                          |
|--------------------|-----------------------------|--------------------------|
| 28. ___ Allergies  | 34. ___ Hepatitis A / B / C | 40. ___ Psychological    |
| 29. ___ Arthritis  | 35. ___ Heart disease       | 41. ___ Rheumatic Fever  |
| 30. ___ Asthma     | 36. ___ High blood pressure | 42. ___ Seizures         |
| 31. ___ Cancer     | 37. ___ Low blood pressure  | 43. ___ Thyroid disease  |
| 32. ___ Depression | 38. ___ Lung disease        | 44. ___ Vascular disease |
| 33. ___ Diabetes   | 39. ___ Neurological        | 45. ___ Other            |
- 
- 
-

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Illness/Injuries/Surgeries/Hospitalizations:**

- |                                |                               |                               |
|--------------------------------|-------------------------------|-------------------------------|
| 46. ___ Broken bones           | 56. ___ Frequent accidents    | 64. ___ Recreational Injuries |
| 47. ___ Burns                  | Sports injuries               | 65. ___ Serious cuts          |
| 48. ___ Car accidents          | 57. ___ Frequent Illness      | 66. ___ Serious Depression    |
| 49. ___ Concussion             | 58. ___ Frequent Infections   | 67. ___ Significant trauma    |
| 50. ___ Fallen down/upstairs   | 59. ___ Head trauma           | 68. ___ Surgeries             |
| 51. ___ Fallen from any height | 60. ___ Hospitalizations      | 69. ___ Transfusions          |
| 52. ___ Fallen on ice          | 61. ___ Infected wounds       | 70. ___ Transplants           |
| 53. ___ Feeling un-coordinated | 62. ___ Loss of consciousness | 71. ___ Tripping/Stumbling    |
| 54. ___ Fevers                 | 63. ___ Psychological         | 72. ___ Wounds slow to heal   |
| 55. ___ Flu/colds              | Hospitalization               |                               |
- 
- 
- 

**Childhood:**

- |                          |                       |               |
|--------------------------|-----------------------|---------------|
| 73. ___ Illnesses        | 75. ___ Immunizations | 77. ___ Other |
| 74. ___ Traumatic events | 76. ___ Injuries      | 78. ___ Other |
- 
- 
- 

**General Health:** List times of day or any correlating factors

- |   |                                 |                                       |
|---|---------------------------------|---------------------------------------|
| 79. ___ Poor appetite                         | 90. ___ Hours of sleep/night    | 103. ___ Radiating pain               |
| 80. ___ Heavy appetite                        | 91. ___ Day napping ___ amt     | 104. ___ Numbness/tingling            |
| 81. ___ Change in appetite                    | 92. ___ Night sweats            | 105. ___ Pins and needles             |
| 82. ___ Unexplained Weight gain/loss          | 93. ___ Sudden energy drop      | 106. ___ Sweats easily                |
| 83. ___ Poor sleep                            | 94. ___ Strong thirst hot/cold  | 107. ___ Excessive sweating           |
| 84. ___ Wake feeling tired                    | 95. ___ Fatigue                 | 108. ___ Body odor change             |
| 85. ___ Decreased sleep                       | 96. ___ Chills                  | 109. ___ Stress                       |
| 86. ___ Heavy sleep                           | 97. ___ Sudden temp changes     | 110. ___ Bowel/bladder changes        |
| 87. ___ Insomnia                              | 98. ___ Localized weakness      | 111. ___ Bleed/bruise easily (where?) |
| 88. ___ Apnea/Narcolepsy                      | 99. ___ Tremors                 |                                       |
| 89. ___ Sudden awakening at night, time _____ | 100. ___ Poor circulation       |                                       |
|   | 101. ___ Peculiar tastes/smells |                                       |
|   | 102. ___ Night pain             |                                       |
- 
- 
- 

**Musculoskeletal:** List location and type of pain, i.e. sharp, dull, radiating, traveling, etc...

- |                      |  |                                   |
|----------------------|--|-----------------------------------|
| 112. ___ Neck Pain   | 115. ___ Joint Pain                      | 117. ___ Irretractable night pain |
| 113. ___ Muscle Pain | 116. ___ Other muscle or joint problems? | 118. ___ Scar tissue adhesions    |
| 114. ___ Back Pain   |  |                                   |
- 
- 
-

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Head, Eyes, Ears, Nose and Throat: List any noticeable correlation and frequency these conditions occur**

- |   |                                   |                                |
|---|-----------------------------------|--------------------------------|
| 119. ___ Dizziness                          | 127. ___ Color blindness          | 136. ___ Heavy ear wax         |
| 120. ___ Migraines<br>Auras, Sounds, Smells | 128. ___ Cataracts                | 137. ___ Nose bleeds           |
| 121. ___ Headaches                          | 129. ___ Glaucoma                 | 138. ___ Sinus problems        |
| 122. ___ Vision problems                    | 130. ___ Spots in eyes            | 139. ___ Mucus                 |
| 123. ___ Near/Far sighted                   | 131. ___ Ringing in ears high/low | 140. ___ Dry throat/mouth      |
| 124. ___ Blurry vision                      | 132. ___ Poor hearing             | 141. ___ Copious saliva (lots) |
| 125. ___ Night Blindness                    | 133. ___ Earaches                 | 142. ___ Mouth/tongue sores    |
| 126. ___ Eye strain/pain                    | 134. ___ Ear Pain                 | 143. ___ Sore throats          |
|   | 135. ___ Ear discharge            | 144. ___ Other                 |
- 
- 

**Skin, Hair, and Nails:**

- |                                      |   |  |
|--------------------------------------|---|--|
| 145. ___ Rashes                      | 150. ___ Purpura (red or purple<br>discoloration of the skin) | 155. ___ New moles/growth                      |
| 146. ___ Eczema                      | 151. ___ Hives  | 156. ___ White spots on nails                  |
| 147. ___ Hair/skin texture<br>change | 152. ___ Dandruff   | 157. ___ Absent half moons or<br>ridged nails. |
| 148. ___ Ulcerations                 | 153. ___ Itching  | 158. ___ Other                                 |
| 149. ___ Pimples                     | 154. ___ Loss of hair   | 159. ___ Other                                 |
- 
- 

**Dental:**

- |                                |                         |                                   |
|--------------------------------|-------------------------|-----------------------------------|
| 160. ___ Teeth problems        | 169. ___ Molars         | 177. ___ Swollen/bleeding<br>gums |
| 161. ___ Cavities              | 170. ___ Extractions    | 178. ___ Periodontal Tx           |
| 162. ___ Braces                | 171. ___ Surgeries      | 179. ___ Sealants                 |
| 163. ___ Bridges               | 172. ___ Jaw clicks     | 180. ___ Fluoride Tx              |
| 164. ___ Fillings/amalgams     | 173. ___ Grinding teeth | 181. ___ Dry mouth                |
| 165. ___ Crowns gold/porcelain | 174. ___ Facial pain    | 182. ___ Other _____              |
| 166. ___ Tooth pain            | 175. ___ Implants       | 183. ___ Other _____              |
| 167. ___ Head pain             | 176. ___ Dentures       |                                   |
| 168. ___ Jaw pain              |                         |                                   |
- 
- 

**Neurologic:**

- |                                |  |  |
|--------------------------------|--|--|
| 184. ___ Balance problems      | 190. ___ Loss of strength                  | 195. ___ Frequently dropping<br>things |
| 185. ___ Vertigo               | 191. ___ Weakness limb/body                | 196. ___ Loss of hand grip             |
| 186. ___ Nausea                | 192. ___ Feel un-coordinated               | 197. ___ Loss of fine motor skills     |
| 187. ___ Vomiting              | 193. ___ Stumbling/tripping                | 198. ___ Other _____                   |
| 188. ___ Sudden blurry vision  | 194. ___ "Running into walls or<br>things" | 199. ___ Other _____                   |
| 189. ___ Loss of consciousness |  |  |
- 
-

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Cardio Vascular:

- |                              |                               |                             |
|------------------------------|-------------------------------|-----------------------------|
| 200. ___ High blood pressure | 205. ___ Phlebitis            | 210. ___ Hand/feet swelling |
| 201. ___ Dizziness           | 206. ___ Chest Pain           | 211. ___ Rapid pulse        |
| 202. ___ Blood Clots         | 207. ___ Cold hands/feet      | 212. ___ Heaviness in chest |
| 203. ___ Low blood pressure  | 208. ___ Difficulty breathing | 213. ___ Other _____        |
| 204. ___ Fainting            | 209. ___ Irregular heartbeat  | 214. ___ Other _____        |
- 

### Respiratory and Lungs:

- |   |   |                    |
|---|---|--------------------|
| 215. ___ Persistent Cough                         | 219. ___ Production of phlegm<br>Y /N _____ Color | 223. ___ Pneumonia |
| 216. ___ Coughing Blood                           | 220. ___ Tight chest                              | 224. ___ Asthma    |
| 217. ___ Difficulty breathing<br>while lying down | 221. ___ COPD                                     | 225. ___ Other     |
| 218. ___ Asthma                                   | 222. ___ Bronchitis                               |                    |
- 

### Genito-Urinary:

- |  |  |                             |
|--|--|-----------------------------|
| 226. ___ Pain w/urination                                | 230. ___ Frequent Urination<br>_____ color | 233. ___ Urgency to urinate |
| 227. ___ Loss of bladder function                        | _____ odor                                 | 234. ___ Impotency          |
| 228. ___ Wake to urinate<br>_____ x's/ night; time _____ | 231. ___ Blood in urine                    | 235. ___ Prostate problems  |
| 229. ___ Kidney stones                                   | 232. ___ Venereal disease/STD              | 236. ___ Other _____        |
- 

### Gastrointestinal:

- |   |  |                             |
|---|--|-----------------------------|
| 237. ___ Pain or cramps                   | 242. ___ Hemorrhoids                           | 245. Bowel movements        |
| 238. ___ Vomiting                         | 243. ___ Laxative use:<br>_____ wk; type _____ | _____ Frequency/day/wk      |
| 239. ___ Rectal pain                      | 244. ___ Bowel Changes                         | _____ Color                 |
| 240. ___ Bloody stools<br>bright/dark red |  | _____ Odor (foul)           |
| 241. ___ Sensitive abdomen                |  | _____ Form (loose, compact) |
|   |  | Texture (smooth, segmented) |
- 

### Gynecology and pregnancy:

- |  |   |                                 |
|--|---|---------------------------------|
| 246. ___ Age of 1 <sup>st</sup> menses   | 254. ___ Birth Control type and<br>duration | What month?<br>_____            |
| 247. ___ Flow (describe)                 |   | 260. ___ Breast Lumps (tender?) |
| 248. ___ Period ___ days                 |   | 261. ___ PMS                    |
| 249. ___ Clots                           | 255. ___ Number of pregnancies              | 262. ___ Mood Changes           |
| 250. ___ Vaginal Sores                   | 256. ___ Number of births                   | 263. ___ Body Changes           |
| 251. ___ Vaginal discharge<br>_____ odor | 257. ___ Live births                        | 264. ___ Cramps                 |
| _____ color                              | 258. ___ Premature births;<br>duration of   | 265. ___ Bloating               |
| _____ appearance                         | pregnancy? _____                            | 266. ___ Nausea                 |
| 252. ___ Irregular Periods               | 259. ___ Miscarriages;                      | 267. ___ Vomiting               |
| 253. ___ Last Menses                     |   | 268. ___ Menopause _____        |
-

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Appliances or Aids:**

- |                            |                               |                       |
|----------------------------|-------------------------------|-----------------------|
| 269. ___ Glasses/Prisms    | 273. ___ Prosthetics          | 277. ___ Pace Maker   |
| 270. ___ Contacts          | 274. ___ Implants of any kind | 278. ___ Hearing Aids |
| 271. ___ Orthotics         | 275. ___ Braces               | 279. ___ Other        |
| 272. ___ Joint replacement | 276. ___ Splints              | 280. ___ Other        |
- 

**Neuropsychological:**

- |                         |   |
|-------------------------|---|
| 281. ___ Seizures       | 287. ___ Concussions                                  |
| 282. ___ Depression     | 288. ___ Easily stressed                              |
| 283. ___ Anxiety        | 289. ___ Considered/attempted suicide                 |
| 284. ___ Poor memory    | 290. ___ Treated for emotional concerns               |
| 285. ___ Foggy thinking | 291. ___ Antidepressant medications                   |
| 286. ___ Bad Temper     | 292. ___ Other neurological or psychological concerns |
- 

**Lifestyle and Social History:**

**Stress Screening: (Y/N)**

- 293. \_\_\_ Can you relax when you want?
  - 294. \_\_\_ Have trouble dealing with stress?
  - 295. \_\_\_ Are you in therapy or counseling? Does it help?
  - 296. \_\_\_ Is your family safe to express true emotions?
  - 297. \_\_\_ Are romantic relationships fulfilling?
  - 298. \_\_\_ Does stress leads to digestive problems?
  - 299. \_\_\_ Do you abuse food/alcohol/tobacco to deal w/unpleasant feelings?
  - 300. \_\_\_ Do you vent unpleasant emotions in a satisfying way?
  - 301. \_\_\_ Do you avoid conflicts at your expense?
  - 302. \_\_\_ Do you feel your health is out of your hands?
  - 303. \_\_\_ Have you tried to deal with stress, but couldn't succeed?
  - 304. \_\_\_ Do you feel capable of resolving your problems, but simply need to know how?
  - 305. \_\_\_ How much do you love yourself? 0-----100%
- 

**Do you find any dysfunction or concern in the following areas? (Y/N)**

- |                                     |  |
|-------------------------------------|--|
| 306. ___ Relationship with Family   | 314. ___ Intimate relationships        |
| 307. ___ Relationships with friends | 315. ___ Sex                           |
| 308. ___ Social Skills              | 316. ___ Religious Life _____          |
| 309. ___ Career                     | 317. ___ Spiritual Path _____          |
| 310. ___ Work                       | 318. ___ Childhood Religious teachings |
| 311. ___ Leisure Time               | 319. ___ Past relationships            |
| 312. ___ Hobbies                    | 320. ___ Childhood                     |
| 313. ___ Past time activities       | 321. ___ School                        |
-

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Lifestyle Habits: List type and quantities where valid**

- |   |                                   |
|---|-----------------------------------|
| 322. ___ Exercise: type _____<br>frequency/week _____ | 326. ___ Recreational drugs use   |
| 323. ___ Sports _____                                 | 327. ___ Un-protected sex         |
| 324. ___ Walks: frequency/week _____                  | 328. ___ Un-necessary risk taking |
| 325. ___ Smoke/chew tobacco                           | 329. ___ Road Rage                |
|   | 330. ___ Seek conflict            |

**Family History: Medical, psychological, social**

- |                                     |   |
|-------------------------------------|---|
| 331. ___ History of Chief Complaint | 351. ___ Mental illness                                 |
| 332. ___ Anemia                     | 352. ___ Migraines                                      |
| 333. ___ Alcoholism                 | 353. ___ Multiple Sclerosis                             |
| 334. ___ Allergies                  | 354. ___ Muscular Dystrophy                             |
| 335. ___ ALS (Lou Gerhig's)         | 355. ___ Neglect  |
| 336. ___ Arthritis                  | 356. ___ Neuropathy (numbness, tingling, pain, burning) |
| 337. ___ Asthma                     | 357. ___ Neuromuscular disease                          |
| 338. ___ Back/spine problems        | 358. ___ Parkinson's                                    |
| 339. ___ Cancer                     | 359. ___ Physical abuse                                 |
| 340. ___ Dementia/Alzheimer's       | 360. ___ Sexual abuse                                   |
| 341. ___ Depression                 | 361. ___ Seizures                                       |
| 342. ___ Diabetes                   | 362. ___ Rigid upbringing                               |
| 343. ___ Family violence            | 363. ___ Rigid Religious beliefs                        |
| 344. ___ Headaches                  | 364. ___ Stroke   |
| 345. ___ Heart Disease              | 365. ___ Suicide (or attempted)                         |
| 346. ___ High blood pressure        | 366. ___ Thyroid disease                                |
| 347. ___ High cholesterol           | 367. ___ Tremors  |
| 348. ___ Low cholesterol            | 368. ___ Vascular disease                               |
| 349. ___ Lung disease               | 369. ___ Other _____                                    |
| 350. ___ Mental abuse               | 370. ___ Other _____                                    |

**Cancellation Notice:** Please Read and Initial

**I understand that The Healing Center has a 24-hour Advance Cancellation Policy. Patients canceling with less than 24 hours notice will be charged for their visit.** Initials \_\_\_\_\_

**Authorization:** Please Read and Sign

*The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.*

*I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.*

*I understand that I am ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.*

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_