CONFIDENTIAL CASE HISTORY

Name _____ Birth date _____ Age ____ M/F _____
Address_____ City _____ Zip/PC _____
Occupation _____ Height _____ Weight _____ Marital Status _____
# of children _____ Family doctor _____Specialists _____
Phone (home) _____ (work)_____ Cell _____
Email _____

Please put an "x" in the box in front of those ailments listed below which may pertain to you.

- ☐ Heart trouble
- ☐ Varicose veins
- ☐ Low blood pressure
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Poor circulation
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest/Upper back pain
- ☐ Excessive sweating
- ☐ Hemophilia
- ☐ Migraines
- ☐ Dizziness
- ☐ Headaches
- ☐ Body weight issues
- ☐ Thyroid function (high/low)
- ☐ Shortness of breath
- ☐ Lung disorders
- ☐ Increased mucus
- ☐ Repetitive clearing of throat
- ☐ Coughing
- ☐ Persistent dry cough
- ☐ Coughing up mucus
- ☐ Asthma
- ☐ Sinus problems
- ☐ Arthritis
- ☐ Joint pain
- ☐ Lower back pain
- ☐ Muscle pain
- ☐ Spinal issues
- ☐ Fibromyalgia
- ☐ Sciatica
- ☐ Carpal tunnel
- ☐ Tendonitis
- ☐ Leg pains/cramps/spasms
- ☐ Skin rashes
- ☐ Dry skin
- ☐ Dandruff
- ☐ Eczema
- ☐ Psoriasis
- ☐ Allergies
- ☐ Kidney infection
- ☐ Bladder infection
- ☐ Pain with urination
- ☐ Interrupted urine flow
- ☐ Incontinence
- ☐ Edema, if yes, where? _____
- ☐ Digestive disorders
- ☐ Constipation
- ☐ Diarrhea
- ☐ Alternating const./diarrhea
- ☐ Gas/Flatulence
- ☐ Bloating
- ☐ Pain after eating
- ☐ Ulcers
- ☐ Burping/heartburn
- ☐ Nausea
- ☐ Hypoglycemia/Low blood sugar
- ☐ Diabetes/High blood sugar
- ☐ Alternating blood sugar
- ☐ Low Energy
- ☐ Fatigue
- ☐ Chronic fatigue
- ☐ Insomnia
- ☐ Jerky motions
- ☐ Epilepsy
- ☐ PMS
- ☐ Hormonal Imbalance
- ☐ Hot flashes
- ☐ Mood swings
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Nervousness
- ☐ Feelings of persistent sadness
- ☐ Melancholy
- ☐ Irritable

WATER: How many 8oz glasses/bottles/cups per day? _____
What type of water (e.g. tap, well, bottled, etc.) _____

If you drink any of the following, indicate how many cups/glasses per day:
Coffee ____ Tea ____ Herbal Tea ____ Milk ____ Fruit juice ____ Veg. Juice ____ Diet Soda ____
Soda ____ Filtered water ____ Bottled water ____ Tap water ____ When do you drink your water?_____

EXCERSISE: How many days/week? _____ For how long? (mins/hrs) _____ Type _____

SLEEP: How many hours per night? (average) _____ Do you wake rested? Yes/No Is sleep interrupted? Yes/No
How often? _____ At what time(s) _____ AM/PM Due to urination? Y/N ____

Do you **SMOKE**? Yes/No If yes, how many cigarettes/day? ____ Have you **ever** smoked? Yes/No
Age started ____ For how long? _____ Does anyone else in your family/household/work smoke? Yes/No

Continued on back - please turn over

ALCOHOL: How often (per/day or per/week) do you have: Beer _____ Wine (red/white) _____
Mixed drinks _____ Liqueurs/ice wine _____ If any, how much? _____
Have you ever been treated for alcholoism? Yes/No If Yes, how long ago? _____

DRUGS: Do you use any recreational drugs? Yes/No Type _____ How often? _____
Have you **ever** used any recreational drugs? Yes/No Type _____ How often? _____
Have you ever been treated for drug dependency? Yes/No If Yes, how long ago? _____

WORK: How many hours/day? _____ How many days/week? _____ Do you enjoy your work? Yes/No
What is your occupation? _____

LEISURE: How many hrs/day do you: Watch TV _____ Read _____ Listen to music _____ (state type listened to _____) Sit in front of a computer _____
Practice spiritual or relaxation methods _____ (state type practiced_____)
Do you take vacations? Yes/No If Yes, how often? _____
When was your last vacation? _____

STRESS: Level you are experiencing right now: ___ Minimal ___ Average ___ Considerable ___ Unbearable
Is the main stressor: __ financial __ job-related __ interpersonal __ marriage __ health
__ unfulfilled expectations __ family members __ spiritual

CHIEF COMPLAINT/CONCERN: What are your main health complaints/reason for visit?
_____
_____

Other therapies: Please list any other therapies you are having. (e.g. chiropractic, physio, acupuncture, etc.)
_____
_____

What are you taking now and why?:
Over the counter drugs _____
Vitamins/Minerals _____
Herbal Remedies _____
Other _____
Prescription drugs _____
Have you ever been hospitalized? Y/N ____ why? _____

FAMILY HISTORY: List hereditary diseases; age; relative health. If deceased, reason for death.
Grandparents: _____
Father: _____
Mother: _____
Brother/Sister: _____
Children: _____

Female: Are you pregnant? Yes/No Number of successful pregnancies ____ Number of miscarriages _____
Menopausal? Yes/No Peri-menopausal? Yes/No Hysterectomy? Yes/No If yes, full or partial? _____

DIETARY HABITS: Please list what you ate and drank in your last three meals and snacks:
Breakfast Supper

Lunch Snacks