



Confidential Case History

Dear Client: Please complete BOTH SIDES of this questionnaire. Thank you!

Name _____ Date _____

Street address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Date of Birth _____

Cell Phone _____ Pager _____ Email _____

Occupation _____ Spouse Name _____

Dr. Name _____ Referred by _____

Are you taking any medication? _____ Vitamins, minerals or other supplements? _____

(Please specify) _____

In case of emergency, contact: _____

Please describe your present symptom or major complaint **(if none, turn this sheet over)**

Has there been a medical diagnosis? _____ What is it? _____

When was it made? _____ By whom? _____

When did you first notice the complaint? _____

What brought it on? _____

What aggravates the condition? _____

Is this condition getting better? _____ Worse? _____ Constant? _____ Comes and goes? _____

What have you done to get relief? _____

Do you have difficulty with any of the following?

GENERAL

- Allergy
- Cancer
- Chills
- Convulsions
- Depression
- Diabetes
- Dizziness
- Epilepsy
- Fainting
- Fatigue
- Fever
- Fibromyalgia
- Goiter
- Headache
- Hypoglycemia
- Immune Disorder
- Loss of Sleep
- Nervousness
- Numbness/Tingling
- Stress
- Sweats / Tremors
- OTHER

GASTRO-INTESTINAL

- Acid Reflux
- Belching or gas
- Colitis / IBS
- Constipation / Diarrhea
- Difficult Digestion
- Gall Bladder trouble
- Hemorrhoids
- Kidney problems
- Liver problems
- Stomach / Ulcer
- OTHER

MUSCLE AND JOINT

- Arthritis / Bursitis
- Hand / Wrist / Elbow trouble
- Foot / Ankle / Knee trouble
- Fractures
- Gout
- Low Back / Hip Pain
- Neck Pain or Stiffness
- Upper Back / Shoulder Pain
- Sciatica
- Strains or Sprains
- Swollen joints
- OTHER

EYES, EARS, NOSE, THROAT

- Eye / Vision problems
- Ear noises
- Frequent Colds
- Frequent Earaches
- Frequent Nosebleeds
- Frequent Sore Throat
- Hay Fever / Allergies
- Chronic Hoarseness
- Sinus Infection
- OTHER

RESPIRATORY

- Asthma
- Chest pain
- Chronic Cough
- Difficulty Breathing
- Emphysema
- OTHER

Other _____

List surgeries, broken bones, Infectious diseases

CARDIO-VASCULAR

- Hardening of Arteries
- High Blood Pressure
- Low Blood Pressure
- Heart trouble
- Poor Circulation
- Stroke
- Varicose Veins
- OTHER

SKIN

- Bruise Easily
- Dryness
- Eczema
- Itching
- Psoriasis
- OTHER

GENITO-URINARY

- Bladder Infections
- Blood in Urine
- Frequent Urination
- Painful Urination
- Prostate trouble
- OTHER

WOMEN ONLY

- Excess Menstrual flow
- Hot Flashes
- Irregular Cycle
- Lumps in Breast
- Painful Menstruation
- OTHER