The Healing Path

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Confidential Case History

Name _____ DOB ____/_____/_____Email:_____

Address_____City_____State_____Zip_____

Telephone Home_____Work_____Ext___Cell_____

Marital Status: ___S ___M ___D ___Sep ___W Occupation_____

Who is responsible for this account?_____Referred by_____

In case of emergency notify_____Phone_____

MAJOR COMPLAINT	**ANY OTHER AREAS OF PAIN OR CONCERN**
1. Who brought it on?	**PAST HISTORY**
2. When did you first notice?	1. Have you had a similar problem before? Yes No
	If yes, when?
3. What activities aggravate condition?	2. Any allergies
	3. Attending Physician / Chiropractor
4. Is condition getting progressively worse? Yes No	Address Phone
Continuous___ Comes and goes ___	
5. Is this condition interfering with your work___ sleep___	4. Are you on any medication? If yes, please list
daily routine___	
6. What do you believe is wrong with you?	5. Are you taking any of the following:
	( ) laxatives ( ) aspirin ( ) sedatives ( ) vitamins ( ) herbs
7. What have you done to get relief?	( ) sleeping pills ( ) minerals ( ) insulin ( ) blood thinners
8. Has there been a medical diagnosis?	**HABITS** **Heavy** **Mod** **Light** **None**
If yes, what was it? By whom?	Alcohol Coffee Tea Tobacco Exercise
Xrays? MRI? Blood Work?	**NOTES:**
MINOR COMPLAINT	

Have you ever had an operation? ___ If yes describe_____

Broken bones? ___ If yes describe_____

Been in an accident? Yes___ No___ Date_____Injuries?_____

Date_____Injuries?_____

DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING?

( ) Headaches	( ) Muscle spasm in neck	( ) Cold sweats
( ) Shooting head pain	( ) Grating in neck	( ) Liver trouble
( ) Sinus trouble	( ) Tightness in shoulders	( ) Gall bladder trouble
( ) Loss of smell	( ) Neuritis in shoulders and arms	( ) Indigestion
( ) Hayfever	( ) Pins and needles in arms and hands	( ) Intestinal gas
( ) Asthma	( ) Cold hands	( ) Constipation
( ) Loss of taste	( ) Chest pains	( ) Kidney trouble
( ) Tightness in throat	( ) Shortness of breath	( ) Bladder trouble
( ) Inflammation of throat	( ) TB	( ) Diabetes
( ) Thyroid trouble	( ) Heart pain	( ) Cancer
( ) Face flushed	( ) Heart palpitations	( ) Sleeping problems
( ) Twitching of face	( ) Heart attacks	( ) Painful joints
( ) Loss of memory	( ) High blood pressure	( ) Swollen joints
( ) Fatigue	( ) Low blood pressure	( ) Arthritis
( ) Depression	( ) Anemia	( ) Slipped disc
( ) Head feels too heavy	( ) Rheumatic fever	( ) Pinched nerves in back
( ) Dizziness	( ) Nervous stomach	( ) Pins and needles in legs
( ) Fainting	( ) Stomach trouble	( ) Swollen ankles
( ) Loss of balance	( ) Ulcers	( ) Cold feet
( ) Ringing in ears	( ) Nerves and nervousness	( ) Pains in legs and feet
( ) Wear glasses	( ) Inner tension	
( ) Light before eyes	( ) Irritability	( ) Other

What is the age of your mattress? _____years _____months _____ comfortable ____ uncomfortable

Do you use a foam pillow? ____ Do you sleep on your ____side ____back ____stomach?

Are you wearing ____heel lifts ____ sole lifts ____arch supports ____inner soles?

NOTES:_____

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Signature_____ Date_____