DuChene Natural Health Center

Patient Case History

I f you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

Patient Information

Last	*First*	*Middle Initial*

How can we help you? (Please, mark all that apply)

☐ Treatment of Pain	☐ Cranial Work	☐ Nutritional Counseling
☐ Sports Performance Enhancement	☐ Pelvic Stabilization	☐ Weight Loss Program
☐ Balance and Coordination Training	☐ Brain Balancing	☐ Detoxification Program
☐ Other		

What are your health concerns?

What is your major symptom? ____________________

What does this prevent you from doing or enjoying? ____________________

When did it start? ____________________ Is this the first time you experienced it? **Yes No**

How did it originally occur? ____________________

Has it become worse recently? **Yes No Same Better Gradually Worse**

How frequent is the condition? **Constant Intermittent Night Only**

How long does it last? **All Day Few Hours Minutes Only with movement**

Are there any other conditions or symptoms that may be related to your major symptom? **Yes No**

If yes, describe: ____________________

Please list any other health concerns: ____________________

Describe the pain: **Sharp Dull Numbness Tingling Aching Burning Stabbing Other:** __________

What have you found to make the problem better? ____________________

What have you tried to do that has not helped? ____________________

What makes the problem worse? **Standing Sitting Lying Bending Lifting Twisting Other:** __________

List any major accidents you have had other than those that might be mentioned above: __________

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? **Yes No Uncertain**

Remarks: ____________________

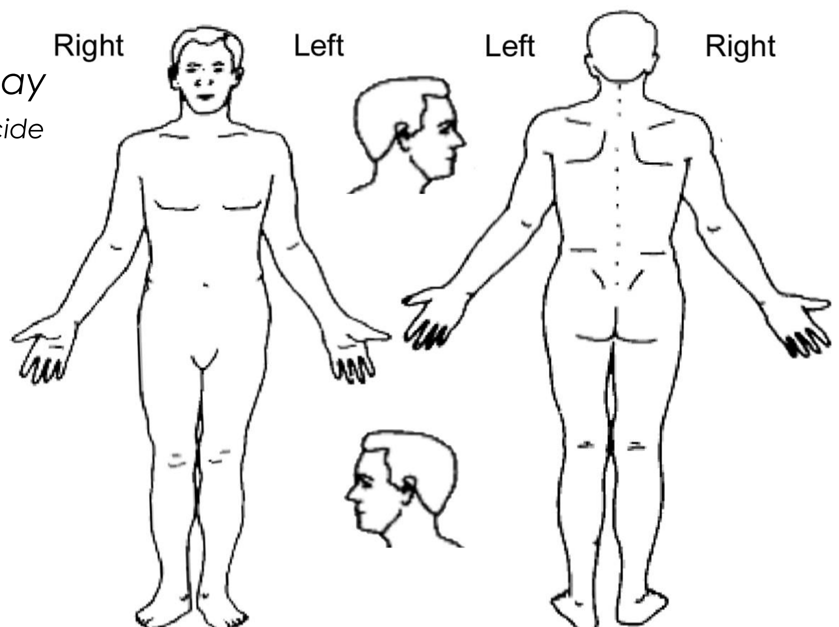
Please circle your pain intensity today

0 – no pain, 10 – pain that causes thoughts of suicide

0 1 2 3 4 5 6 7 8 9 10

Please mark the areas of all your complaints that were not mentioned above.

N – Numbness	*S – Soreness*
T – Tingling	*P – Pain*
A – Ache	*ST – Stiffness*



Lifestyle & Habits

Supplementation Do you take a multi-vitamin? ☐ Yes ☐ No What brand?

Please, list any other supplements you are taking

Supplement	Reason	Supplement	Reason
1.		4.	
2.		5.	

Exercise	Do you follow an exercise plan?	☐ Yes	☐ No
	What kind of exercise do you get?		
	How often do you exercise?		
Diet	Are you dieting	☐ Yes	☐ No
	What is your diet like?		
	Do you crave salts or sugar?	☐ Yes	☐ No Salt Sugar
	Do you consume artificial sweeteners?	☐ Yes	☐ No
	Do you consume Soy products?	☐ Yes	☐ No
Water	How much water do you drink?		
Caffeine	Do you drink caffeine?	☐ Yes	☐ No
	What, how much and how long?		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	How much and how long?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	How much and how long?		
Rest	Does it take longer than 5 minutes to fall asleep	☐ Yes	☐ No
	Do you wake up in the middle of the night?	☐ Yes	☐ No
	Do you feel rested when you wake up?	☐ Yes	☐ No

Notes:

Family History

Please circle the following conditions as they pertain to your immediate family.

Diabetes	Mother	Father	Brother	Sister	Grandparent
Heart disease	Mother	Father	Brother	Sister	Grandparent
Back pain	Mother	Father	Brother	Sister	Grandparent
Stroke	Mother	Father	Brother	Sister	Grandparent
Kidney problems	Mother	Father	Brother	Sister	Grandparent
Cancer	Mother	Father	Brother	Sister	Grandparent
Obesity	Mother	Father	Brother	Sister	Grandparent

Conditions

Please circle the conditions as they pertain to you.

Arthritis	Autoimmune Disease	Diabetes	Appendicitis
Osteoporosis	Anemia	Cancer	Mental disorder
Whiplash	Heart disease	HIV positive	Allergies

Is there any other condition that we should know about? ☐ Yes ☐ No

What is it?

Injuries

*List any **auto collisions** that you were involved in, either as the driver or passenger, below no matter how insignificant you may think. Begin with the most recent.*

Type of collision	Type of treatment received	Date of collision
1.		
2.		
3.		

*List any **job injuries** that you experienced, below no matter how insignificant you may think. Begin with the most recent.*

Type of job injury	Type of treatment received	Date of job injury
1.		
2.		
3.		

*List any **other injuries** caused by falls or impacts, no matter how insignificant you may think. Begin with the most recent.*

Type of injury	Type of treatment received	Date of injury
1.		
2.		
3.		

Hospital

		Notes:
Do you have a pacemaker?	☐ Yes ☐ No	
Have you ever had a lapse of memory?	☐ Yes ☐ No	
Have you ever had a spinal tap or injection?	☐ Yes ☐ No	
Were you ever knocked unconscious?	☐ Yes ☐ No	
Have you had knee or hip replacement surgery?	☐ Yes ☐ No	
Do you have any other implantable medical devices in your body?	☐ Yes ☐ No	
Have you had any surgeries?	☐ Yes ☐ No	
Do you have any broken Bones?	☐ Yes ☐ No	

Please circle all of the following procedures as they pertain to you.

Gall bladder removal — Back surgery — Neck surgery — Upper extremity surgery — Lower extremity surgery

Medications

List any prescription or over-the-counter medications you are currently taking.

Medication	Reason	Medication	Reason
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Have you ever read the side effects of the medication you are on? ☐ Yes ☐ No

Review of systems

Please, mark all of the following that are of concern to you.

General

☐ weight gain	☐ chills	☐ convulsions	☐ depression	☐ dizziness
☐ loss of weight	☐ fatigue	☐ fever	☐ nervousness	☐ consistent fainting

Notes:

Gastro-intestinal

☐ rectal bleeding	☐ diarrhea	☐ gall bladder problem	☐ poor digestion	☐ constipation
☐ liver problems	☐ acid reflux	☐ stomach pain	☐ poor appetite	☐ nausea

Notes:

Eye/ear/nose/throat

☐ asthma	☐ sore throat	☐ tonsillitis	☐ sinus infections	☐ circles under eyes
☐ ear noises	☐ enlarged thyroid	☐ frequent colds	☐ poor vision	☐ allergies

Notes:

Respiratory

☐ spitting phlegm	☐ chronic cough	☐ difficulty breathing	☐ spitting blood	☐ chest pain

Notes:

Muscle/joints/bones

☐ twitching	☐ foot problems	☐ back pain	☐ painful tailbone	☐ stiff neck
☐ spinal curvature	☐ swollen joints	☐ neck pain	☐ headache	☐ weakness

Notes:

Cardio-vascular

☐ heart trouble	☐ high blood pressure	☐ low blood pressure	☐ ankle swelling	☐ pain over heart
☐ stroke	☐ rapid heart	☐ slow heart	☐ poor circulation	☐ heart fluttering

Notes:

Skin or allergies

☐ bruise easily	☐ dryness	☐ hives	☐ allergies	☐ body odor
☐ sensitive skin	☐ eczema	☐ itching	☐ anal itching	☐ bad breath

Notes:

Women

☐ cramps	☐ excessive flow	☐ hot flashes	☐ irregular cycle	☐ painful periods

Are you pregnant	☐ Yes ☐ No	Are you on birth control?	☐ Yes ☐ No
Are you having fertility problems?	☐ Yes ☐ No	Are you on hormone replacement?	☐ Yes ☐ No

Notes:

I understand and agree to the following:

- *A history, consultation, examination and x-rays are conducted for diagnostic and informational purposes and I am requesting these services if needed.*
- *It is my responsibility to complete the clinic's forms accurately.*
- *It is my responsibility to notify the doctor if any of my information has changed or requires updating.*
- *Original x-rays are the clinic's property and copies of the original films and reports will be released to me upon written request*

Please sign here

Patient or guardian signature

Date