Name_____ Date_____

In addition to the comprehensive Case History that follows, please answer the following CASE REVIEW QUESTIONS.

- **Some of the questions will be duplicated in the Case History, so don't worry.**
- **Please type out your answers and with as much detail as possible.**
- **These must be returned with your Case History forms before your appointment.**

HEALTH HISTORY QUESTIONS

1. Please list your education, profession, sports and hobbies
2. List your chief complaints in order of your importance
3. Provide a detailed narrative (story) of your health history in a timeline sequence
4. List all diagnoses given to you in a timeline sequence and your personal opinions about the diagnosis
5. List your opinion on what you think has happened to your health
6. List of all healthcare providers you have consulted and their opinions and treatments about your case
7. List any treatments, medications, or supplements that have improved your health
8. List any treatments, medications, or supplements that have caused reactions or decreased your health
9. List in a timeline sequence and medications you have taken
10. List in a timeline sequence any medical procedures or surgeries you have had
11. List in a timeline sequence any significant laboratory or imaging results
12. List in a timeline sequence any exposure to environmental, industrial, or toxic compounds.
13. List any history of infections (excluding common colds).

PERSONAL OPINION QUESTIONS

Please do not answer, "I don't know" to any of these questions

1. Why do you think healthcare practitioners have failed with your case?
2. Do you think your condition can be cured, or improved?
3. What do you consider a realistic time frame to see changes in your health under our care?
4. What are your expectations from us?
5. Is there anyone you blame for your health condition?
6. What specific improvements in your health would you consider a successful outcome in your case?
7. Are you emotionally and spiritually able to handle further investigation and management of your case?
8. Is there anything you feel you should tell us about yourself or your case?
9. Is there anything in what you believe about health and the body that you may think is holding back your health?
10. Are you willing to change what you believe about health and the body to gain more health?
11. Are there any emotional experiences that can be affecting to your health condition?
12. Do you have a distinct purpose in life?
13. Are there any patterns in childhood or adulthood that has contributed to your health problems?
14. Is your spouse and/or family unit supportive of you with your health condition?
15. Are your spouse and/or family unit supportive of you seeking care at our office?
16. How did you feel about answering all of these questions and the case review process?

CHRONIC NEUROLOGICAL & METABOLIC CASE HISTORY

Name _____

How do you wish to be addressed in our office? □ First name □ Mr. □ Mrs. □ Ms. □ Miss □ Dr.

Address _____ City _____State_____ Zip_____

Date of Birth _____ Marital Status: Single Married Widowed Divorced

Home Telephone _____ Cell _____Work_____

Email address: _____

Occupation _____ Employer _____

Spouse/Partner's Name _____ Employer _____

Spouse/Partner's Work Ph_____ Cell Ph _____

Name of person to contact in case of emergency:_____

Relationship:_____ Phone_____

How did you choose our office? (e.g. Referral, internet, advertisement etc.)

_____

What is the main problem or symptom that made you come here today?:

_____

When and How did this begin? _____

Have you had this or similar conditions in the past? □ Yes □ No If yes, when? _____

What aggravates your condition? _____

What makes it better? _____

Describe what you are feeling? _____

Do you experience Numbness or Tingling? □ No □ Yes If yes, where? _____

SYMPTOM INTENSITY: Please circle the number describing the intensity of your symptoms.

None → 0 1 2 3 4 5 6 7 8 9 10 ←**Unbearable**

When you're awake, how often are you feeling these symptoms? (0-100%) _____%
Is this getting progressively worse? □ Yes □ No **Is your condition:** □ Constant □ Comes & goes
Is this condition interfering with your: □ Work □ Sleep □ Daily routine □ Other _____
Has there been any medical diagnosis of your complaint? □ Yes □ No If yes, list the Dr.'s name and the

Diagnosis _____

How have you tried to take care of this problem in the past? **Circle all that apply**

Medications • Emergency Room • Surgery • Routine Medical • Exercise • Supplements •Regular

Chiropractic • Other (please specify)_____

How did the previous method(s) work out for you? **Circle all that apply**

Bad results • Some Results • Great Results • Nothing Changed • Didn't get worse • Didn't work very long

What are you afraid this might be? _____

Please list any medications you currently take and for what conditions:_____

_____

_____

Please list any natural supplements you currently take and for what conditions:_____

_____

_____

Please list your 5 major health concerns in order of importance to you.

1. _____
2. _____
3. _____
4. _____
5. _____

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Autoimmune Disease
- ☐ Blood pressure Problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Migraine Headaches
- ☐ Neurological Problems (Parkinson's, Paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose Veins

Other_____

Medical MEN

- ☐ Benign prostatic hyperplasia
- ☐ Prostrate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other_____

Medical WOMEN

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other_____

Date of last GYN exam_____

Mammogram ☐+ ☐-

Pap ☐+ ☐-

Form of birth control_____

# of children_____

# of pregnancies_____

- ☐ C-section

Age of first period_____

Date -last menstrual cycle _____

Length of cycle____days

Interval of time between cycle_____days

Any recent changes in normal menstrual flow(e.g., heavier, large clots, scanty)

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Infertility
- ☐ Learning Disabilities
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Migraine Headaches
- ☐ Neurological Disorders (Parkinson's, Paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

other_____

Past Evaluations

Here is a list of possible testing and evaluations you may have had. If you have had any of these please make sure to send copies of these results and reports with this questionnaire. (*We do not need daily office notes*).

- MRI, CT, EEG
- Psychological / Neuropsychological Evaluations
- Psychiatric
- Neurological Evaluations
- Gastroenterology Evaluations
- Rheumatology Evaluations
- Internal Medicine Evaluations
- Genetic Evaluations
- Celiac/Gluten testing

Hospitalizations

Age	Reason for Hospitalization	Discharge Summary Attached?

Age	Operations	
	Appendix	
	Hernia	
	Tonsils	
	Adenoids	
	Tubes in Ears	
	Other Surgery:	

Please describe any head injuries, broken bones or other injuries / traumas	Age

List surgical operations and years:

_____

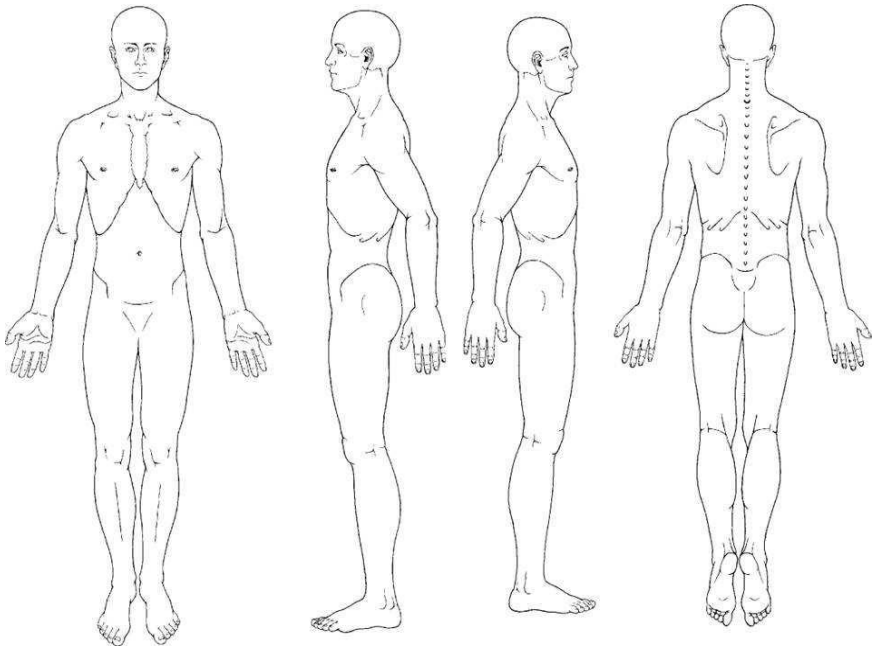
Other Medical or Physical conditions you have been diagnosed with (e.g. diabetes, heart conditions, arthritis, osteoporosis, low thyroid, hormone imbalance, food allergies, anxiety or panic attacks etc.)

_____

_____

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe your problem.

PPP	PAIN
WWW	WEAKNESS
NNN	NUMBNESS
HHH	HEAT
TTT	TINGLING
BBB	BURNING
CCC	CRAMPING
FFF	STIFFNESS



Write "Y" for Yes or "N" for NO in the box next to each of the questions.

	Weakness		**Fatigue**
	Pins & Needle feelings, Electric Shock feelings		**Racing Heart**
	Trouble controlling bowels or bladder		**Angina - chest pain or shortness of breath**
	Hair loss on the arms or legs		**Left arm Pain**
	Balance problems		**Swelling in the lower legs**
	Fingernails are brittle or have ridges or look different		**Extreme shortness of breath; feel like drowning/ suffocating**
	Symptom changes with arm, leg or neck movements		**Blackouts**
	Twitching muscles		**Light headedness**
	Decrease in size or tone of your arms or legs		**Cramping pains in the legs that starts after walking**
	Uncoordinated		**Poor exercise tolerance**
	Muscle cramping		**Erectile dysfunction**

	Double Vision?		**Sensitivity to light**
	Difficulty Talking?		**Sweat more on one side (armpit, face etc.)**
	You feel unsteady or you fall		**Dry mouth**
	Vomiting, sick to stomach		**Dry eyes**
	Abnormal jerking of the eyes		**Cold arms, legs, hands, feet**
	Numbness? Where?		

Please mark the following in each category by ranking each one 0-4.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

RB			
	Difficulty remaining seated when expected		Trouble sustaining attention in routine situations
	Difficulty remembering where things are		Trouble recognizing the emotion in someone's voice
	Bad memory for directions		Don't respond well to new situations
	Difficulty understanding body language		Don't understand the "big Picture" of words / phrases
	Often don't get humor and metaphors		Not Able to "read between the lines"
	Act compulsively		Inappropriate social behavior and responses
	Difficulty with word problems		Not Able to focus
	Difficulty following through or finishing things		Not Able to 'tune out' irrelevant stimuli
	Trouble imagining or visualizing an activity or physical action		Not Able to speak without sounding monotone
	Trouble with reading comprehension		Blurting out of answers before question is complete
	Hyperactive-move excessively		Trouble understanding symbolism in words and art
	Not Able to control what you say		Not Able to cry or be spontaneous
	Not able to predict what others will do		Irregular heart rate (fast or slow)
	Feel fearful and anxious		Easily distracted by ordinary insignificant things

LB			
	Not Able to remember facts and figures		Trouble understanding when spoken to
	Not Able to speak clearly		Not Able to identify objects by name
	Can't find words when talking		Trouble with fine motor skills (small objects, handwriting, buttons)
	Not Able to draw pictures accurately		Not Able to focus on smaller details
	Difficulty with calculations/math		Depression (even in the past)
	Trouble reading (dyslexic) - even if past only		Trouble following multiple step directions
	Upset if routine or plan changes		Irregular heart rhythm (skipped beats, fluttering)
	Have repetitive thoughts		Excessively motivated
	Start things, but don't finish		Very good at finding mistakes
	Can't turn thoughts off at night		Tend to write very small

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific _____

What would be different/better without this problem? Please be specific _____

_____

What do you desire most to get from working with us? _____

_____

What is that worth to you? _____

_____

What is your idea of the ideal doctor? _____

_____

_____

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ **Date:** _____

BE SURE TO COMPLETE THE LAST 2 PAGES OF THIS HISTORY—IT IS A 6-DAY DIET RECORD. <u>THIS MUST BE COMPLETED</u>.

For Doctor's Use Only

Please mark the following in each category by ranking each one 0-5.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently, 5=Always

	0	1	2	3	4	5	Past ONLY	Comments
Letters seen backwards	☐	☐	☐	☐	☐	☐	☐	_____
Difficulty counting, calculating	☐	☐	☐	☐	☐	☐	☐	_____
You have difficulty understanding how you feel	☐	☐	☐	☐	☐	☐	☐	_____
Without looking, have difficulty knowing "where" in space your foot or hand is	☐	☐	☐	☐	☐	☐	☐	_____
Feel odd sensations (bugs crawling, tingling, burning, etc.)	☐	☐	☐	☐	☐	☐	☐	_____
Get claustrophobic, tunnel vision, or feeling the world is closing in	☐	☐	☐	☐	☐	☐	☐	_____
Have difficulty understanding how others fee	☐	☐	☐	☐	☐	☐	☐	_____
Gets surprised by things coming from the left side(more than from opposite side)	☐	☐	☐	☐	☐	☐	☐	_____
Difficulty with "spatial" skills	☐	☐	☐	☐	☐	☐	☐	_____
Difficulty with word problems in math	☐	☐	☐	☐	☐	☐	☐	_____
Difficulty getting dressed	☐	☐	☐	☐	☐	☐	☐	_____
Difficulty reading people's facial expressions	☐	☐	☐	☐	☐	☐	☐	_____
Difficulty interpreting emotional content of a verbal conversation	☐	☐	☐	☐	☐	☐	☐	_____
Confusion between right and left	☐	☐	☐	☐	☐	☐	☐	_____
Dry eyes, nose, mouth or tearing of eyes and running of the nose, excess saliva	☐	☐	☐	☐	☐	☐	☐	_____
Difficulty with arousal (i.e. waking up), seem to be half asleep all the time	☐	☐	☐	☐	☐	☐	☐	_____
Speech is slurred	☐	☐	☐	☐	☐	☐	☐	_____
Movement does not look coordinated	☐	☐	☐	☐	☐	☐	☐	_____
Trip	☐	☐	☐	☐	☐	☐	☐	_____
Fall, get hurt running, climbing	☐	☐	☐	☐	☐	☐	☐	_____
Have trouble maintaining balance	☐	☐	☐	☐	☐	☐	☐	_____
Knock over things when reaching	☐	☐	☐	☐	☐	☐	☐	_____
Drop things	☐	☐	☐	☐	☐	☐	☐	_____

Please mark the following in each category by ranking each one 0-5.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently, 5=Always

	0	1	2	3	4	5	Past ONLY	Comments:
Feelings of sadness	☐	☐	☐	☐	☐	☐	☐	_____
Moodiness	☐	☐	☐	☐	☐	☐	☐	_____
Negativity	☐	☐	☐	☐	☐	☐	☐	_____
Low energy	☐	☐	☐	☐	☐	☐	☐	_____
Irritability	☐	☐	☐	☐	☐	☐	☐	_____
Suicidal Feelings	☐	☐	☐	☐	☐	☐	☐	_____
Low self esteem	☐	☐	☐	☐	☐	☐	☐	_____
Forgetfulness	☐	☐	☐	☐	☐	☐	☐	_____
Face, lip movements, or noises	☐	☐	☐	☐	☐	☐	☐	_____
Feelings of hopelessness about the future	☐	☐	☐	☐	☐	☐	☐	_____
Feelings of helplessness or powerlessness	☐	☐	☐	☐	☐	☐	☐	_____
Feeling dissatisfied or bored	☐	☐	☐	☐	☐	☐	☐	_____
Excessive guilt	☐	☐	☐	☐	☐	☐	☐	_____
Crying easily	☐	☐	☐	☐	☐	☐	☐	_____
Lowered interest in things considered fun	☐	☐	☐	☐	☐	☐	☐	_____
Appetite changes	☐	☐	☐	☐	☐	☐	☐	_____
Very sensitive to smells and odors	☐	☐	☐	☐	☐	☐	☐	_____
Poor sense of smell	☐	☐	☐	☐	☐	☐	☐	_____
Mild paranoia	☐	☐	☐	☐	☐	☐	☐	_____
Memory problems	☐	☐	☐	☐	☐	☐	☐	_____
Periods of forgetfulness	☐	☐	☐	☐	☐	☐	☐	_____
Spaciness or confusion	☐	☐	☐	☐	☐	☐	☐	_____
Periods of panic	☐	☐	☐	☐	☐	☐	☐	_____
Frequent misinterpetation of comments as negative when they are not	☐	☐	☐	☐	☐	☐	☐	_____
Auditory or visual hallucinations	☐	☐	☐	☐	☐	☐	☐	_____
Sudden fear, anger or sexual feelings	☐	☐	☐	☐	☐	☐	☐	_____
History of family violence or explosiveness	☐	☐	☐	☐	☐	☐	☐	_____
Short fuse or periods of extreme irritability	☐	☐	☐	☐	☐	☐	☐	_____
Periods of rage without provocation	☐	☐	☐	☐	☐	☐	☐	_____
Dark thoughts or thoughts of suicide, homicide	☐	☐	☐	☐	☐	☐	☐	_____
Preoccupation with moral or religious ideas	☐	☐	☐	☐	☐	☐	☐	_____
Reading comprehension problems	☐	☐	☐	☐	☐	☐	☐	_____
Irritability that tends to build, then explode	☐	☐	☐	☐	☐	☐	☐	_____
Ringing in the ears	☐	☐	☐	☐	☐	☐	☐	_____

Please mark the following in each category by ranking each one 0-5.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently, 5=Always

	0	1	2	3	4	5	Past ONLY	Comments:
Teeth grinding	☐	☐	☐	☐	☐	☐	☐	_____
Tics	☐	☐	☐	☐	☐	☐	☐	_____
Muscle cramps	☐	☐	☐	☐	☐	☐	☐	**Where?**_____
Restless legs	☐	☐	☐	☐	☐	☐	☐	_____
Tremors	☐	☐	☐	☐	☐	☐	☐	**Where?**_____
Bites or chews fingers	☐	☐	☐	☐	☐	☐	☐	_____
Obsessive thoughts	☐	☐	☐	☐	☐	☐	☐	_____
Gets stuck on a behavior	☐	☐	☐	☐	☐	☐	☐	_____
Gets song stuck in head	☐	☐	☐	☐	☐	☐	☐	_____
Panic attacks	☐	☐	☐	☐	☐	☐	☐	_____
Poor handwriting	☐	☐	☐	☐	☐	☐	☐	_____
Low motivation	☐	☐	☐	☐	☐	☐	☐	_____
Excessive Motivation	☐	☐	☐	☐	☐	☐	☐	_____
Quick startle reaction	☐	☐	☐	☐	☐	☐	☐	_____
Persistent phobias	☐	☐	☐	☐	☐	☐	☐	_____
Easily embarrassed	☐	☐	☐	☐	☐	☐	☐	_____
Easily sweats	☐	☐	☐	☐	☐	☐	☐	_____
Hot or cold flashes/ hot or cold hands	☐	☐	☐	☐	☐	☐	☐	_____
Feelings if nervousness or anxiety	☐	☐	☐	☐	☐	☐	☐	_____
Tremors / shakiness	☐	☐	☐	☐	☐	☐	☐	_____
Heart pounding, rapid heart rate, chest pain	☐	☐	☐	☐	☐	☐	☐	_____
Trouble breathing or feelings of being smothered	☐	☐	☐	☐	☐	☐	☐	_____
Avoidance of public places from fear of anxiety	☐	☐	☐	☐	☐	☐	☐	_____
Periods of nausea and stomach upset	☐	☐	☐	☐	☐	☐	☐	_____
Tendency to predict the worst	☐	☐	☐	☐	☐	☐	☐	_____
Fear of being judged or scrutinized	☐	☐	☐	☐	☐	☐	☐	_____
Excessive worry of what others think	☐	☐	☐	☐	☐	☐	☐	_____
Tendency to freeze in an anxiety provoking situations	☐	☐	☐	☐	☐	☐	☐	_____

Please mark the following in each category by ranking each one 0- 4.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

	0	1	2	3	4	Past ONLY	Comments:
Sensitive to odors, perfumes, smoke	☐	☐	☐	☐	☐	☐	
Sensitive to pollens, molds	☐	☐	☐	☐	☐	☐	
Extreme sugar cravings (child seeks out sugary foods)	☐	☐	☐	☐	☐	☐	
Genital rash (vaginal, "jock Itch")	☐	☐	☐	☐	☐	☐	
Ringworm	☐	☐	☐	☐	☐	☐	
Fungus on toenails or fingernails	☐	☐	☐	☐	☐	☐	
Repeated use of antibiotics (even in distant past)	☐	☐	☐	☐	☐	☐	
Repeated use of steroids	☐	☐	☐	☐	☐	☐	
Mouth thrush (yeast infection)	☐	☐	☐	☐	☐	☐	
Dark skin under eye: looks like you might have a mild "black-eye"	☐	☐	☐	☐	☐	☐	
Bloating	☐	☐	☐	☐	☐	☐	
Belching	☐	☐	☐	☐	☐	☐	
Intestinal gas	☐	☐	☐	☐	☐	☐	
Constipation	☐	☐	☐	☐	☐	☐	
Diarrhea	☐	☐	☐	☐	☐	☐	
Indigestion	☐	☐	☐	☐	☐	☐	
Esophageal reflux	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	
Itching, tingling or burning (child may scratch a lot, or tell you)	☐	☐	☐	☐	☐	☐	
Hives, psoriasis or dandruff	☐	☐	☐	☐	☐	☐	
Acne	☐	☐	☐	☐	☐	☐	
Hair loss	☐	☐	☐	☐	☐	☐	
Chronic infections(repeated infections)	☐	☐	☐	☐	☐	☐	
Your symptoms/behaviors worse in the following weather: Damp, Hot, Misty, Moldy, Musty	☐	☐	☐	☐	☐	☐	
Bronchitis	☐	☐	☐	☐	☐	☐	
Congestion with changing seasons	☐	☐	☐	☐	☐	☐	
Cough	☐	☐	☐	☐	☐	☐	
Pneumonia	☐	☐	☐	☐	☐	☐	
Post nasal drip	☐	☐	☐	☐	☐	☐	
Sighing	☐	☐	☐	☐	☐	☐	
Sinus fullness	☐	☐	☐	☐	☐	☐	
Wheezing	☐	☐	☐	☐	☐	☐	

***** Write down EVERYTHING you eat & drink for 6 days. *****
What you're eating and when you're eating can have a HUGE NEGATIVE EFFECT on your health.

Day 1

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack	**Snack**	**Snack**
Time:	**Time:**	**Time:**

Day 2

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack	**Snack**	**Snack**
Time:	**Time:**	**Time:**

Day 3

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack	**Snack**	**Snack**
Time:	**Time:**	**Time:**

***** Write down <u>EVERYTHING</u> you eat & drink for 6 days. *****
What you're eating and when you're eating can have a <u>HUGE NEGATIVE EFFECT</u> on your health.

Day 4

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack	**Snack**	**Snack**
Time:	**Time:**	**Time:**

Day 5

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack	**Snack**	**Snack**
Time:	**Time:**	**Time:**

Day 6

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Snack	**Snack**	**Snack**
Time:	**Time:**	**Time:**