EQUINOX
INTEGRATIVE WELLNESS CENTER
RESTORING HEALTH AND MAINTAINING WELLNESS

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire and sign. This confidential history will be part of your permanent records.

Name: _____ D.O.B. _____ Sex: □ M □ F
Address: _____ City: _____ PC: _____

Home Phone: _____ Work: _____ Cell: _____
e-mail: _____

Marital Status: □ M □ S □ D □ W Spouse's Name:_____Children/Age: _____
Occupation: _____ Employer _____
Who referred you to us? _____ How else did you hear about us? _____

Which of our services are you here for today?
□ Chiropractic Care □ Physical Therapy □ Pain Management □ Acupuncture
□ Nutritional Evaluation □ Massage Therapy □ M.D. Care □ ND Care

What is your major complain? _____
_____
How long have you had this condition? _____
Have you had similar conditions in the past? _____
Have you previously seen another doctor for this condition? □ YES □ NO Where? _____

(SKIP THE FOLLOWING QUESTIONS IF YOU ARE HERE FOR A NUTRITIONAL EVALUATION)
Do any positions make it feel worse? _____
Do any positions make it feel better? _____
Is this condition: □ Improved □ Unchanged □ Getting Worse
Is this condition interfering with you: □ Work □ Sleep □ Daily Routine □ Other:
Other doctors or therapists who have treated **THIS** condition: _____
List surgical operations and years: _____
_____
_____
Do you have a family physician? □ YES □ NO
Name: _____ Phone#:_____

Medications, dosage and frequency: _____
_____
_____
Have you been in an auto accident or had any other personal injury? □ YES □ NO Describe: _____
_____

Signature: _____ **Date**: _____
Parent/Guardian: _____ **Date**: _____

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REVIEW OF SYSTEMS: *Check only the ones you now **have** or have **had** in the past.*

General	Now	Past
Weakness	□	□
Fatigue	□	□
Fever	□	□
Chills	□	□
Night Sweats	□	□
Fainting	□	□
Skin		
Color Changes	□	□
Nail Changes	□	□
Hair Changes	□	□
Moles	□	□
Rashes	□	□
Sores	□	□
Weakness	□	□
Head		
Headaches	□	□
Injuries	□	□
Bumps	□	□
Last Eye Exam	_____	
Glasses	□	□
Contacts □	□	
Cataracts	□	□
Ears		
Hard of Hearing	□	□
Deafness	□	□
Ringing	□	□
Discharges	□	□
Earaches□	□	
Itching	□	□
Dizziness	□	□
Room Spins	□	□
Nose		
Decrease Smell	□	□
Bleeding □	□	
Pain	□	□
Discharge	□	□
Obstruction	□	□
Post Nasal Drip	□	□
Deviated Septum	□	□
Mouth		
Bleeding Gums	□	□
Sores	□	□
Dental Problems	□	□
Bad Breath	□	□
Loss of Taste	□	□
Dry Mouth	□	□
Ulcers	□	□
Blisters	□	□

Throat	Now	Past
Soreness	□	□
Bad Tonsils	□	□
Hoarseness	□	□
Pain	□	□
Trouble Swallowing	□	□
Recurrent Infection	□	□
Neck		
Neck Enlargement	□	□
Stiff Neck	□	□
Soreness	□	□
Lumps	□	□
Masses	□	□
Breast		
Discharge	□	□
Lumps	□	□
Pain	□	□
Bleeding	□	□
Nipple Changes	□	□
Skin Changes	□	□
Bloated	□	□
Lungs		
Cough	□	□
Phlegm	□	□
Blood	□	□
Short of Breath	□	□
Wheezing	□	□
Pain	□	□
Congestion	□	□
Inhalant Exposure	□	□
Heart		
Heart Murmur	□	□
Palpitations	□	□
Rapid Heartbeat	□	□
Swollen Extremities	□	□
Cold Extremities	□	□
Chest: Pain/Pressure	□	□
Varicose Veins	□	□
Blood Clots	□	□
Blue Extremities	□	□
Blood		
Anemia	□	□
Low Blood Iron	□	□
Easy Bruising	□	□
Easy Bleeding	□	□
Swollen Nodes	□	□
Painful Nodes	□	□
Sugar in Blood	□	□
Red Spots	□	□

Gastrointestinal	Now	Past
Abdominal Pain	□	□
Nausea	□	□
Bloated	□	□
Belching	□	□
Heartburn	□	□
Indigestion	□	□
Irregular Bowels Habits	□	□
Constipation	□	□
Diarrhea	□	□
Gas	□	□
Hemorrhoids	□	□
Poor Appetite	□	□
Food Intolerance	□	□
Bloody Stools	□	□
Black Stools	□	□
Genitourinary		
Urgency	□	□
Incontinence	□	□
Straining	□	□
Back Pain	□	□
Frequent Voiding	□	□
Stones	□	□
Burning	□	□
Bed Wetting	□	□
Small Stream	□	□
Discharge	□	□
Impotence	□	□
Dribbling	□	□
Cloudy Urine	□	□
Urine Color: _____		
Spotting Between Periods	□	□
Menstrual Cramps	□	□
Discharge	□	□
Itching	□	□
Painful Intercourse	□	□
Irregular Periods	□	□
Hot Flashes	□	□

Contraception Type: _____
Age at 1st Period: _____
Duration of Cycle: _____ No. of Pregnancies: _____ No. of Births: _____ No. of Miscarriages: _____
No. of Abortions: _____
Menstrual Flow:
□ Heavy □ Mod. □ Light
Last Period: _____
Las Pap Smear: _____
Last Vaginal Exam: _____
Last Mammogram: _____
Last Prostate Exam: _____

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Neurological	Now	Past
Seizures	□	□
Vertigo	□	□
Dizziness	□	□
Hand Trembling	□	□
Loss of Sensation	□	□
In-coordination	□	□
Loss of Facial	□	□
Weak Grip	□	□
Paralysis	□	□
Speech Difficulty	□	□
Tingling	□	□
Loss of Memory	□	□
Numbness	□	□

Endocrine

Weight Loss	□	□
Weight Gain	□	□
Extremely Thin	□	□
Heat Intolerance	□	□
Cold Intolerance	□	□
Hair Changes	□	□
Breast Changes	□	□

Immunization/Vaccination

	Now	Past
DPT	□	□
Mumps	□	□
Small Pox	□	□
Typhoid	□	□
Tetanus	□	□
Measles	□	□
Pneumococcal	□	□
Influenza	□	□
Polio	□	□
MMR	□	□

Blood Type

A+ □ A- □
B+ □ B- □
C+ □ C- □
O+ □ O- □
Other: _____

Blood Transfusions

Date: _____
Date: _____
Date: _____
Date: _____

Psychiatric	Now	Past
Hyperventilation	□	□
Insecurity	□	□
Depression	□	□
Trouble Sleep	□	□
Irritable	□	□
Indecisive	□	□
Timid	□	□
Hallucinations	□	□
Loss of Memory	□	□
Alcoholism	□	□
Drug Addiction	□	□
Drug Dependency	□	□
Suicidal Thoughts	□	□
Anxiety	□	□
Sexual Problems	□	□

Musculoskeletal

Muscle Pain	□	□
Muscle Weakness	□	□
Muscle Cramps	□	□
Muscle Twitching	□	□
Joint Stiffness	□	□
Joint Pain	□	□

PAST MEDICAL HISTORY: *Please check only the ones you have had in the past.*

Hay Fever	□	Parasites	□
Mumps	□	Epilepsy	□
Rheumatic Fever	□	Paralysis	□
Allergies	□	Polio	□
Angina	□	Mental Illness	□
Cancer	□	Alcoholism	□
Tumor	□	Depression	□
Blood Disease	□	Nervous Breakdown	□
Leukemia	□	Migraine	□
Heart Trouble	□	Gout	□
Varicose Veins	□	Hemorrhoids	□
Phlebitis	□	Prostate Problems	□
Hypertension	□	Sexual Problems	□
Stroke	□	Gonorrhea	□
Ulcers	□	Syphilis	□
Jaundice	□	Diabetes	□
Skin Trouble	□	Bladder Trouble	□
Gallstones	□	Kidney Stones	□
Liver Trouble	□	Kidney Infection	□
Hepatitis	□	Dysentery	□

Date of Last Chest X-Ray: _____ □ Normal □ Abnormal
Last TB Skin Test: _____ □ Normal □ Abnormal

Allergies: _____
_____
_____

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FAMILY HISTORY: *List any of the diseases listed above which run in your family.*

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY: *Check the boxes and fill in.*

Current Weight:_____lbs. Have you recently lost or gained weight?_____

MentalWork □ Heavy □ Moderate □ Light Hours per day: _____

Physical Work □ Heavy □ Moderate □ Light Hours per day: _____

Exercise □ Heavy □ Moderate □ Light Hours per day: _____

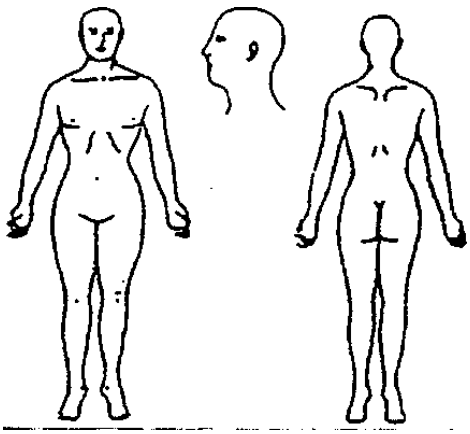
Type: _____

Smoking □ Current □ Previous Packs/Day:_____ # of years: _____

Alcohol Beer/Week:_____Liquor/Week:_____Wine/Week: _____ # of years: _____

Caffeine (Coffee, tea, cola, etc) Cups/Day: _____ # of years: _____

Aspirin No./Day: _____ # of years: _____ Others: _____



Mark the Areas of your Symptoms on the Figure to the Left:
(Use the following symbols: *Aches ^^^^ Numbness °°°° Pins/Needles •••• Stabbing ////*)

Mark an "X" on the lines:
How bad are you symptoms now?

0_____5_____10

None Most Severe

How bad have they been in the past?

0_____5_____10