NeuroLife Case History/Patient Information

Date:_____ Patient # _____ Doctor: _____

Name:_____ Nickname:_____ Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Fax # _____ Cell Phone:_____

Age:_____ Birth Date:_____ Race: _____ Marital: M S W D

Occupation: _____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children: _____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Primary Provider & Facility:_____

When doctors work together it benefits you. May we have your permission to update your other providers regarding your care at this office? ☐ Yes ☐ No

HISTORY OF PRESENT ILLNESS: (List complaints in order of importance)

Chief Complaint #1: _____ Date Appeared: _____ ☐ Auto ☐ Work ☐ Other

Chief Complaint #2: _____ Date Appeared: _____ ☐ Auto ☐ Work ☐ Other

Chief Complaint #3: _____ Date Appeared: _____ ☐ Auto ☐ Work ☐ Other

Chief Complaint #4: _____ Date Appeared: _____ ☐ Auto ☐ Work ☐ Other

PAST MEDICAL HISTORY

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Please list any allergies relating to medication, environment, or food: _____

_____

Please list any other health issues you have, no matter how insignificant they may seem: _____

_____

PAST PROVIDERS/TREATMENTS

List ALL providers/facilities utilized (Use additional pages if necessary)

Doctor/Facility Name	Dates	Treatments / Procedures	Results/Effectiveness

REVIEW OF SYSTEMS

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

FAMILY HISTORY:

Parents:

Father: living ___ deceased ___ (check one) Current age if still living: _____
Cause of death and age at death if deceased: _____

Mother: living ___ deceased ___ (check one) Current age if still living: _____
Cause of death and age at death if deceased: _____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do (back pain, headaches, etc.)? If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis___	Cancer_____	Mental Illness____
Diabetes ___	Asthma_____	Heart Disease_____
Stroke ___	Kidney Disease_____	Lung Disease____
Arthritis____	Liver Disease_____	

Other _____

Please check any and all insurance coverage that may be applicable in this case**:**

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

SUMMARY

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
   How did it originally occur? _____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
   If yes, when and how? _____
4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ____
5. Are there any other conditions or symptoms that may be related to your major symptom(s)?
   Yes ___ No ___. If yes, describe: _____
   Are there other unrelated health problems? Yes ___ No ___. If yes, describe _____
   _____
6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ____ Aching ___
   Burning ___ Stabbing ___ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___ If yes, describe: _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
   Lifting ___ Twisting ___ Other: _____

   NO SYMPTOMS _____ EXTREME SYMPTOMS

   Please place an "X" on the line above to indicate level of problem.

9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes ___ No ___ Uncertain ____
11. Additional Comments or Remarks: _____
    _____
    _____
    _____
    _____
    _____

Doctor's Signature _____ Date _____

Pain Drawing

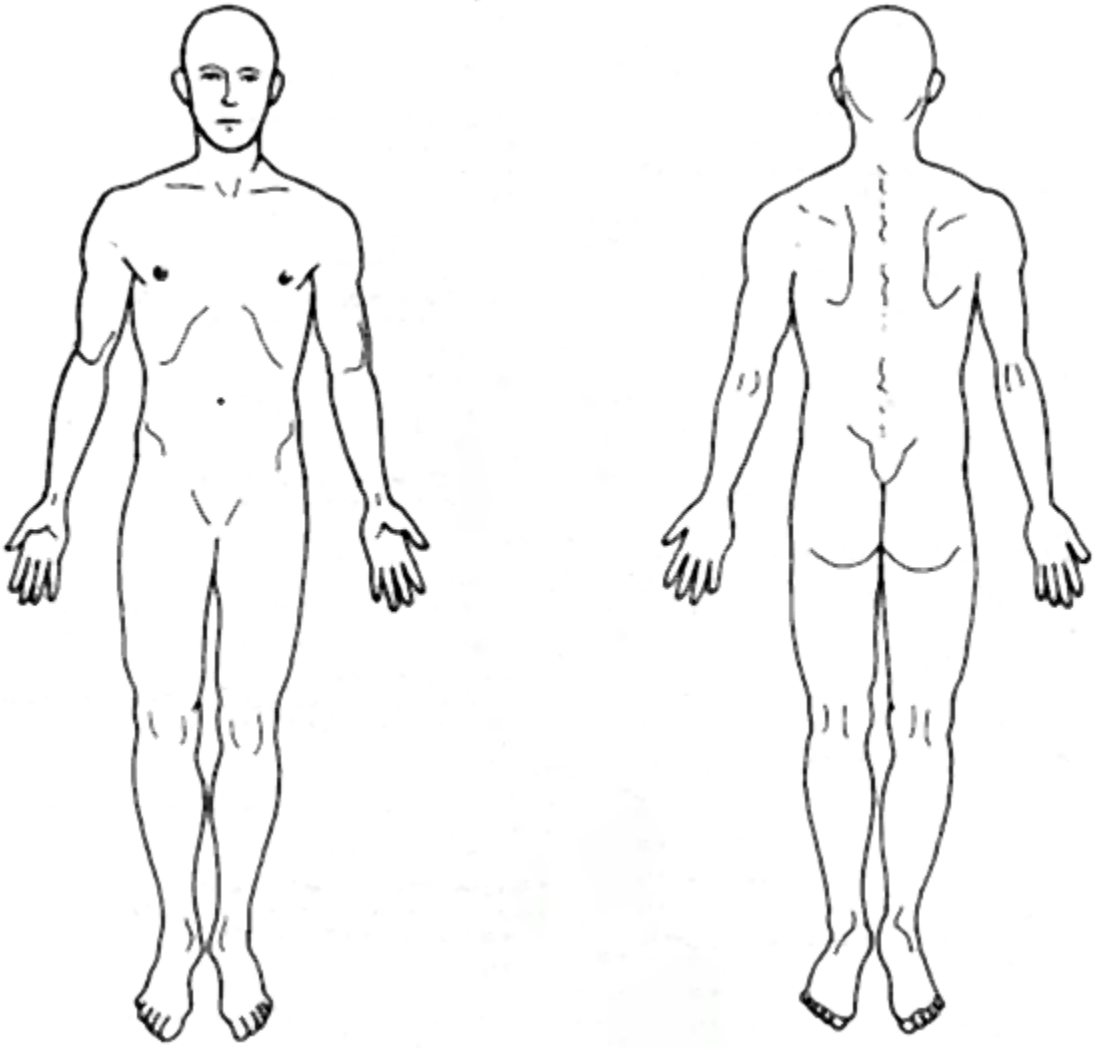
TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

Please list the 5 major health concerns in your order of importance:

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

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relief by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard, dry, or small stool	**0**	**1**	**2**	**3**
Coated tongue of "fuzzy" debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
Use laxatives frequently	**0**	**1**	**2**	**3**

Category II

Excessive belching, burping, or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movements	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested foods found in stools	**0**	**1**	**2**	**3**

Category III

Stomach pain, burning, or aching 1- 4 hours after eating	**0**	**1**	**2**	**3**
Use antacids	**0**	**1**	**2**	**3**
Feel hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief from antacids, food, milk, carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	**0**	**1**	**2**	**3**

Category IV

Roughage and fiber cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness lasts 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Average Bowel Movement Frequency: __ BM / ___ Day(s)
Pecentage Regular: ___% Loose: ___% Constipated: ___%

Category V

Greasy or high-fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates from clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed	**Yes**		**No**	

Category VI

Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep yourself going or started	**0**	**1**	**2**	**3**
Get lightheaded if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, or have tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory/forgetful	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**

Category VII

Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category VIII

Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**0**	**1**	**2**	**3**
Afternoon headaches	**0**	**1**	**2**	**3**
Headaches with exertion or stress	**0**	**1**	**2**	**3**
Weak nails	**0**	**1**	**2**	**3**
Wake up refreshed in the morning	0	1	2	3

Typical hours of sleep per night:

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only.

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle, greater than 32 days	Yes	No
Shortened menses, less than every 24 days	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal? _____

Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcoholic beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke or utilize any form of nicotine?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

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

_____

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

_____