Natural Treatments For Brain And Body

New Patient History Forms

Date of Birth: ____/_____/_____   Today's Date: _____/_____/______

Last Name _____________ First Name: _____________________
Address ____________________________________ Apt# _____________
City: ________________________________ State: _____ Zip: _______________
Phone(H) ____________________ (W) ____________________
(Cell) ____________________
Spouse's Name: ____________________
E-Mail Address: _____________________________
Your occupation: ________________________
Employer: _____________________________
Employer Address: ____
Have you been to another doctor for this problem? Y N Who?_________ When _____/_____/______
Who referred you to our office? ____
____
____

1st Complaint: _____________________________ No. ___

- Date Symptoms first appeared ______/______/______
- Did it begin Accident Gradually Suddenly Progressive
- Pain Value 0 = no pain, 10 = max pain; Current Pain Level 0-10 _________
- What makes the symptoms increase? ______________________________
- Type of pain Sharp Dull Ache Burn Throb Discomfort
- Does the Pain Radiate into Shoulder Arm Elbow Hand
  Fingers Hip Knee Leg Foot Toes Head
  Chest Abdomen
- Do you experience numbness or tingling? YES NO
- How often do you experience these symptoms?
  - 100% 75% 66% 50% 33% 25% 10%
- Pain intensity : Please put a line on the scale below describing the intensity of your pain
- No Pain ____ Unbearable Pain

PATIENT SIGNATURE ______________________ Date_______

2nd Complaint: ____________________________ No. ___

- Date Symptoms first appeared ______/______/______
- Did it begin Accident Gradually Suddenly Progressive
- Pain Value 0 = no pain, 10 = max pain; Current Pain Level 0-10 _________
- What makes the symptoms increase? ________________________________
- Type of pain Sharp Dull Ache Burn Throb Discomfort
- Does the Pain Radiate into Shoulder Arm Elbow Hand
  Fingers Hip Knee Leg Foot Toes Head Chest
  Abdomen
- Do you experience numbness or tingling? YES NO
- How often do you experience these symptoms?
  - 100% 75% 66% 50% 33% 25% 10%
- Pain intensity: Please put a line on the scale below describing the intensity of your pain

No Pain ____ Unbearable Pain

3rd Complaint: ____________________________ No. ___

- Date Symptoms first appeared ______/______/______
- Did it begin Accident Gradually Suddenly Progressive
- Pain Value 0 = no pain, 10 = max pain; Current Pain Level 0-10 _________
- What makes the symptoms increase? ________________________________
- Type of pain Sharp Dull Ache Burn Throb Discomfort
- Does the Pain Radiate into Shoulder Arm Elbow Hand
  Fingers Hip Knee Leg Foot Toes Head Chest
  Abdomen
- Do you experience numbness or tingling? YES NO
- How often do you experience these symptoms?
  - 100% 75% 66% 50% 33% 25% 10%
- Pain intensity: Please put a line on the scale below describing the intensity of your pain

No Pain ____ Unbearable Pain

PATIENT SIGNATURE ______________________ Date_______

Review of Systems (Circle if you are experiencing any of the following)

General: Change in appetite, weight gain, weight loss, fever, chills, sweats

Head: Mild headaches, mild migraines, significant migraines, recent head trauma

Eyes: Near sighted, far sighted, double vision, blurred vision, cataracts

Ears: Ringing in the ears, hearing loss, infections, drainage, pain

Nose/Mouth/Throat: Recurring nosebleeds, chronic sinus congestion, gum bleeding,
Sore tongue, difficulty swallowing, hoarseness

Respiratory: Shortness of breath, cough, coughing up blood, wheezing, snoring,
Excessive daytime sleepiness, episodes of gasping, choking or long pause in breathing at night

Cardiac: Chest discomfort, palpitations, shortness of breath on exertion, at night short of breath

Gastrointestinal: Intermittent diarrhea and constipation, bloating, abdominal pain, nausea, vomiting, blood in stool or by rectum

Genito-urologic (Male): Penile discharge, diminished stream, incomplete emptying of bladder, pain with urination, blood in urine, loss of libido, impotence

Genito-urologic (Female): Loss of urine with coughing or sneezing, sudden urge to urinate with loss of urine, blood in urine, pain with urination, loss of libido

Menstrual: Having regular periods, irregular periods, painful periods, no periods due to menopause since_______, No periods due to hysterectomy since ________

Musculoskeletal: Joint pain, joint swelling, back pain, leg weakness, muscle weakness

Neurological: Dizziness, fainting, numbness or tingling, seizures

Skin: Rashes, non-healing lesion, new or changed moles, previous skin lesions removed or destroyed

Psychiatric: Increased nervousness, mood changes, depression, feelings of hopelessness, problems with sleep, memory, or anxiety

Endocrine: Thyroid trouble, heat or cold intolerance, excessive thirst, hunger or urination.

Hematologic/Lymphatic: Anemia, easy bruising or bleeding, swollen lymph nodes

Allergic/Immunologic: Hay fever, environmental allergies

PATIENT SIGNATURE _____________________ Date_______

Patient Medical & Injury History

Condition # 1 Described: ____

Please List all previous treatments for this condition:

Treating Physician:______________________________ Date: ___________
Type Treatment: _______________________________ Date: ___________

Condition # 2 Described: ____

Please List all previous treatments for this condition:
Treating Physician:______________________________ Date: ___________
Type Treatment: _______________________________ Date: ___________

Condition # 3 Described: ____

Please List all previous treatments for this condition:
Treating Physician:______________________________ Date: ___________
Type Treatment: _______________________________ Date: ___________

Condition # 4 Described: ____

Please List all previous treatments for this condition:
Treating Physician:______________________________ Date: ___________
Type Treatment: _______________________________ Date: ___________

Condition # 5 Described: ____

Please List all previous treatments for this condition:
Treating Physician:______________________________ Date: ___________
Type Treatment: _______________________________ Date: ___________

What do you think is the most important trauma, injury or sickness that is related to your current conditions? List the situations in the order of importance:

____

____

____

____

PATIENT SIGNATURE _________________________ Date________

Natural Treatment for Brain and Body

Patient information   Please List All Past Surgeries, Broken Bones, Sprains

Type ____________________ When ____________________ Doctor _________________
Type ____________________ When ____________________ Doctor _________________
Type ____________________ When ____________________ Doctor _________________
Type ____________________ When ____________________ Doctor _________________
Type ____________________ When ____________________ Doctor _________________

Please List All Past Accidents And Falls:

What ____ When __________
What ____ When __________
What ____ When __________
What ____ When __________
What ____ When __________

Please list any medications you are currently taking:

MEDICATION

_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

Please list any vitamins you are currently taking:

VITAMINS

_____________________ _____________________ _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

Please list any Special Foods you are to eat !

____

____

PATIENT SIGNATURE ______________________ Date_______

Natural Treatments For Brain And Body

Patients History Contributes to Brain Dysfunction, Injury, and Sickness!

Check the boxes that apply to your experiences.

Were you a forceps delivered baby? Difficult birth?
Have you ever worn braces? Mouth splint? Do you have crooked teeth?
Have you ever had teeth extracted? Any fillings, crowns, or root canal work?
Have you ever had cavitation surgery? Implants? Or other non-natural Teeth?
Have you ever been labeled as having TMJ problems?
Is your chin recessed or does it jut forward?
Does your head jut forward? Do you have Chronic Headache with this head posture?
Do you have difficulty keeping your head even with your shoulders?
Do you have dissimilar facial features?
Are your eyes, eyebrows, and ears of even height?
Have you ever fallen down? Hit your head or shoulder or tailbone?
Have you ever banged your head: on a cabinet, a door, getting out of the car?
Have you had any car accident? Even 5 mph fender benders slam you brain into skull bones?
Have you ever ridden a roller coaster, or bumper cars?
Have you ever banged your head playing sports, (soccer, basketball, football)?
Have you ever played football? Professional players have devastating head injuries are you?
Have you ever high dived (swimming) and hit your head on the bottom?
Have you ever done a bad belly flop off the side of the pool?
Have you ever been involved in gymnastics and fallen to the floor?
Have you ever been pregnant?
Have you ever been labeled, ADD, ADHD, dyslexic, learning disability?
Have you ever been on Ritalin to control hyperactivity? ADD, ADHD?
Have you ever been labeled as Chronic Fatigue Syndrome or Fibromyalgia?
Do you experience drops of energy on and off throughout the day?
Do you experience mood swings, emotional outbursts or hopelessness?
Are you overweight and can't seem to lose weight?
Do you gain weight in abdomen and thighs, pear shaped body?
Have you ever experienced an eating disorder?
Do you try to gain weight and can't?
Do you feel the need for coffee or sugar snacks to pick you up?
Do you have headaches? Unexplained body or joint pain?
Do you have irregular or painful menstrual cycles?
Do you have difficulty coping with stressful situations?
Do you "catch" colds/flu/bronchitis frequently?
Do you have trouble remembering things? Short term or long memory?
Do you have numbness or tingling in any part of your body?
Do your arms, hands, legs, or feet shake?
Have you ever experienced Bells Palsy Symptoms?
Have you ever experienced a stroke?
Do you have digestive problems? Gastric Reflux? Ulcers? Leaky Gut?
Do you have hemorrhoids, diverticulitis, colitis, or irritable bowel syndrome?
Do you have chest pain or shortness of breath?

Do you experience "chronic" gallbladder pain? Have you had gallbladder surgery?
Have You ever broken or fractured any bones in your body or head?

Dental History Form

Please circle the questions that apply to you with Y for Yes or N for No.

Y N Have you had braces – orthodontics?
Y N Have you had crowns?
Y N Do you have bridge work?
Y N Do you wear false teeth?
Y N Do you have gum disease?
Y N Do you have silver amalgam fillings?
Y N Do you have missing teeth?
Y N Does your jaw joint pop or make noises?
Y N Have you had teeth pulled to accommodate the use of orthodontic appliances?
Y N Have you had your false teeth adjusted in the last five years?
Y N Have you had any dental surgery?
Y N Do you have crooked teeth?
Y N Do you have an overbite?
Y N Does opening or closing your jaw cause discomfort or pain?
Y N Have you ever had an arch expander?
Y N Have you ever worn a splint?
Y N Have you had wisdom teeth removed?
Y N Do you grind your teeth at night while asleep?
Y N Do you have difficulty breathing though your nose or mouth?
Y N Do you have neck, shoulder or chest pain?
Y N Have you ever hit your head in a car accident?
Y N Have you had any accidents that injured your head – even minor accidents?
Y N Do you have more than one headache a month?
Y N Do you have to take drugs to control face pain or headaches?
Y N Have you been to a neurologist for head or face pain?
Y N Have you had a cat scan, MRI or myelogram associated with head or neck pain?
Y N Has your jaw ever locked open or closed?
Y N Do you have teeth that wear unevenly on your top or bottom teeth?

PATIENT SIGNATURE ______________________ Date_______