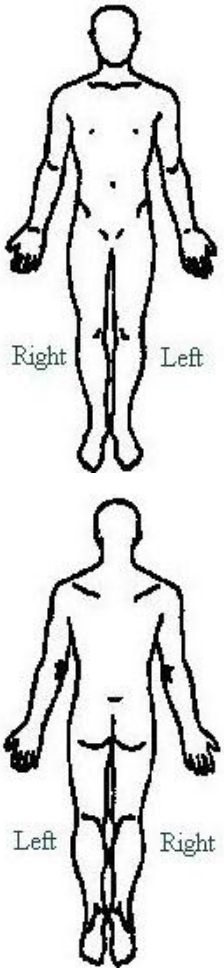
CONFIDENTIAL PATIENT HEALTH HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if NUCCA care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date_____

HISTORY OF PRESENT ILLNESS

Please mark an X on the pictures to the right where you have pain, numbness, or tingling:



What is your major symptom/problem: _____

When did your symptoms first appear? _____

Are your symptoms getting ☐ better ☐ worse ☐ staying about the same?

Have you ever had this problem before? ☐ Yes ☐ No
If so, when: _____

How often do you have this pain/symptom?_____

Is the pain/symptom ☐ constant? Or does it ☐ come and go?

Rate the severity of your pain on a scale from 1 to 10 _____
(1- 3 mild pain, 4-6 moderate pain, 7-10 severe pain with 10 being the worst pain *imaginable*.)

How does it feel? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numb ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiff ☐ Other _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation?

Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down ☐ Other _____

What treatments have you received for this condition? ☐ Medications ☐ Surgery
☐ Chiropractic ☐ Physical Therapy ☐ Massage Therapy ☐ Ice/Heat
☐ Stretching/Exercises ☐ Homeopathic ☐ Other_____

List other doctors who have treated you for this condition:_____

_____

List other symptoms or problems are you currently dealing with?

1. Condition _____

   _____

   _____

2. Condition _____

   _____

   _____

3. Condition _____

   _____

   _____

Name _____ Date_____

REVIEW OF SYSTEMS

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C

GENERAL
☐ ☐ ☐ Allergies
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness
☐ ☐ ☐ Depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT
☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot Trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Poor Posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen joints
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Upper back pain
☐ ☐ ☐ Middle back pain
☐ ☐ ☐ Low back pain
Pain or numbness in:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet

O F C

EYES, EARS, NOSE & THROAT
☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear Discharge
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

GASTRO-INTESTINAL
☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Distension of abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

O F C

CARDIO-VASCULAR
☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY
☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficulty breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

GENITO-UNIRINARY
☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control bladder
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

SKIN
☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

FOR WOMEN ONLY
☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?