

PATIENT CASE HISTORY
ROOTS WELLCARE, PA – Carla Breunig, DC, CCH
Confidential

Please do not wear any hairspray, cologne, perfume, or aftershave when you visit the office.

Name _____
Date _____

What brings you to our office today? _____

How do you hope your life will change as a result of working with us? _____

What are the most significant changes you have made to improve your health? _____

Health Concerns

What are your major health problems/concerns?

Date of onset	Description
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____
6.	_____
7.	_____
8.	_____

Describe the causes of these concerns (if known or suspected): _____

Have you had the same/similar problems before? Yes ___ No ___

What activities worsen your problem? _____

What activities improve your problem? _____

Are your problems getting progressively worse? Yes ___ No ___

Are your problems interfering with your: Work ___ Daily routine ___ Sleep ___ All ___

Other _____

If your condition involves pain, please characterize type:

Ache ___ Sharp ___ Radiating ___ Constant ___ Intermittent ___

Please rate the amount of pain you are generally experiencing (circle one):

Minor 1 2 3 4 5 6 7 8 9 10 *Severe*

Previous Treatment for Health Problems

None____
Name of doctor/hospital: _____
Address: _____
Date first seen: _____ Date last seen: _____
What tests were done, including x-rays? _____
Pertinent test results: _____
Condition or diagnosis: _____
How was the condition treated? _____
Results of treatment: Good ___ Fair ___ Poor ___
Please list below other doctors seen for this condition: None ___

Name	Address	Date	Testing/treatment
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Additional remarks about previous treatment: _____

Current primary care physician: _____
Do you suffer from any other health problems for which you are not seeking consultation with us? Yes ___
No ___ If yes, please itemize below:

Doctor	Condition	Date of onset
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Health Maintenance Update

Please indicate approximate dates and results of last:
Physical examination _____
Spinal examination _____
Dental examination _____
Dental X-ray _____
Cholesterol profile _____
Other blood tests (such as PSA(prostate)) _____
Chest X-ray _____
Spinal X-ray _____
Bone Density (DEXA) Scan _____
Mammogram _____
Eye exam _____
Colonoscopy or flexible sigmoidoscopy _____
Other _____

Please itemize all medications you are currently using, or have used recently. Please be sure to include all over the counter medications and hormones, as well. List dosages and approximate length of time you have been on each medication.

Please list names, brands and dosages of all vitamins, minerals, herbs, and other natural products you are currently using: _____

Please list medication/supplement/environmental allergies or intolerances and the reactions you have experienced to them: _____

Please list past or present exposure to harmful chemicals: _____

Surgical History

Please chronologically indicate all major and minor surgeries you have undergone and their approximate dates: _____

Previous Chiropractic Care

None____
Name of Chiropractor: _____
Address: _____
Dates of treatment: First treatment: _____ Last treatment: _____
Under treatment for what condition at that time? _____
Were X-rays performed? If so, please indicate approximate date and area _____
Cause of trouble as explained by doctor: _____
Results of treatment: Good ___ Fair ___ Poor ___

Previous Homeopathic Care

None____
Name of previous Homeopath: _____
Address: _____
Dates of treatment: First treatment: _____ Last treatment: _____
Under treatment for what condition at that time? _____
Remedies given, if you remember: _____
Results of treatment: Good ___ Fair ___ Poor ___

Serious Accidents and Falls

Have you ever been in an auto accident? No ___ Yes ___ Date _____
Describe: _____
Have you had any sports injuries? No ___ Yes ___ Date _____
Have you had any work accidents? No ___ Yes ___ Date _____
Describe _____
Please describe any other falls, accidents, or injuries and indicate dates: _____

Please list all fractures you have sustained and when they occurred: _____

Early Health History

Did your mother have any known problems during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery)? _____

Were you breastfed or bottlefed? If breastfed, please indicate duration _____

Was your home life during childhood and adolescence loving and supportive, or were there significant stresses? _____

Please check if you had any of the following childhood illnesses:

Frequent ear infections ___ Colic ___ Eczema ___ Recurrent colds ___ Bronchitis ___ Pneumonia ___
Meningitis ___ Other ___

Were you on frequent or prolonged antibiotic therapy? _____

Did you receive standard immunizations? _____

Did you experience any adverse reactions to immunizations? _____

Please check if you have had any of the following conditions:

<input type="checkbox"/> Flu	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Alcohol/drug addiction	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Sexually transmitted infection (name _____)
<input type="checkbox"/> Anemia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Measles	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Mental health problem	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: describe, please
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pleurisy	_____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Polio	<input type="checkbox"/> HIV+/AIDS	_____

Female Health History

Age at first period: ___ Date of last period: _____ # pregnancies: ___ # live births: _____

Date of last Pap test: _____ History of abnormal Pap tests? Yes ___ No ___

History of irregular periods? Yes ___ No ___ Menstrual cycle length: ___ days

Duration of menstrual period: ___ days

Do you experience significant menstrual cramping? Yes ___ No ___

Is heavy bleeding a problem? Yes ___ No ___

Do you have a history of endometriosis? Yes ___ No ___

Do you have a history of infertility? Yes ___ No ___

Do you have excessive unwanted hair growth? Yes ___ No ___

Do you have a tendency toward premenstrual syndrome? No ___ Yes ___ (please describe symptoms) _____

Do you have a family history of breast cancer, ovarian cancer, or osteoporosis?

Yes (circle appropriate condition above) ___ No ___

Describe any current menstrual or menopausal symptoms or concerns: _____

Describe any current breast problems: _____

Did you breast feed? ___ Please indicate duration for each child: _____

Digestive Function

Describe any food intolerances you have: _____

Describe any digestive problems: _____

Bowel movement frequency: _____

Do you usually have to strain to have a bowel movement? Yes ___ No ___

Do you ever have blood with bowel movements? Yes ___ No ___

Are your stools ever black or tarry? Yes ___ No ___

Last time you received antibiotics: _____

Family Health History

Please review the conditions listed below. Indicate those that are current health problems of a family member by writing the letter **C** under his/her column. Use a letter **P** to indicate a past problem. Spaces that do not apply should be left blank. If adopted and history unknown, check here: _____

Condition	Father Age _____	Mother Age _____	Spouse Age _____	Brother/s Ages _____	Sister/s Ages _____	Children Ages _____
Alcoholism/Addiction						
Alzheimer's Disease						
Allergies/hay fever						
Arthritis						
Asthma						
Cancer (indicate type)						
Depression						
Diabetes						
Digestive problems						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problems						
Migraine						
Osteoporosis						
Other (indicate)						
Other (indicate)						

If any of the above family members are deceased, please list their age at death and cause: _____

Lifestyle Habits

Please check major stresses:

Job ___ New retirement ___ New baby ___ Change of marital status ___ Health problems ___

Family stress ___ Financial concerns ___

Abusive relationship ___ Other ___ Pleas describe: _____

Please describe the quality of major relationships in your life _____

Please indicate job satisfaction: Excellent ___ Good ___ Fair ___ Poor ___

Sleep: Time arise: _____ Time retire: _____ Naps: _____

Quality of sleep: Well-rested ___ Tired upon awakening ___ Awaken during night ___

Sleep in total darkness ___ Sleep with some light in room _____

Frequency of vacations: _____/year

Travel frequency: _____

Is your present sex life satisfactory: Yes ___ No ___

Have you experienced physical, emotional, sexual, or verbal abuse? Yes ___ No ___

Exercise: None ___ Type _____ Frequency _____

How do your relax or relieve stress? _____

Coffee (amount/day): _____

Tea (amount/day): _____

Soda pop (amount/day): _____

Liquor: None ___ Type and amount per day and week: _____

Present or former history of alcohol overuse? Yes ___ No ___

Tobacco: None ___ Chew or smoke and amount per day: _____

Number of years using tobacco: _____ Date(s) quit: _____

Recreational drug use: None ___ Type and frequency _____

Former history of recreational drug use? No ___ Yes ___ Please specify _____

Diet History

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Typical snacks: _____

Frequency of dining out: _____ Frequency of eating fast food: _____

Quantity of water consumed/day: _____ Is you water filtered? Yes ___ No ___

Foods you avoid: _____

Foods you crave: _____

History of eating disorder? Yes ___ No ___

MEDICAL SYMPTOMS QUESTIONNAIRE

Initial testing scale: Rate each symptom based upon your health profile for the past 30 days

POINT SCALE:

0=Never or almost never have the symptom

1=Occasionally have it; effect is **not severe**

2=Occasionally have it; effect is **severe**

3=Frequently have it; effect is **not severe**

4=Frequently have it; effect is **severe**

DIGESTIVE FUNCTION

- Nausea or vomiting
- Constipation
- Belching/passing gas
- Bloating
- Heartburn
- Diarrhea

EARS

- Itchy ears
- Earaches/infections
- Ringing in ears/hearing loss
- Drainage from ear

EMOTIONS

- Mood swings
- Anxiety, fear, nervousness
- Anger, irritability, aggression
- Depression

EYES

- Watery or itchy eyes
- Swollen, red, or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision

HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia

HEART

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

LUNGS

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Easily winded

JOINTS/MUSCLES

- Pain or aches in joints
- Arthritis/swelling of joints
- Stiffness/limitation of movement
- Pain or aches in muscles
- Weakness or muscle fatigue

MENTAL AND NEUROLOGIC FUNCTION

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

MOUTH/THROAT

- Chronic coughing
- Gagging, frequently clearing throat
- Sore throat, hoarse, voice loss
- Swollen/discolored tongue, gums, lips
- Canker sores

NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucous formation

SKIN

- Acne
- Hives
- Hair loss
- Flushing or hot flashes
- Excessive sweating

WEIGHT

- Binge eating or drinking
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

OTHER

- Frequent illness
- Frequent or urgent urination
- Loss of bladder control
- Genital itch or discharge

TOTAL SCORE _____

PATIENT NAME: _____ DATE: _____