

# Patient Case History Form

Please complete before consultation.

Full Name

Email

Phone

Gender

Age

Blood Type

Weight

Height

Purpose of Consultation

Your Top 3 Goals

You 3 Greatest Fears

**Are you currently pregnant?**

☐ Yes

☐ No

If yes, how far along? \_\_\_\_\_

Any high risk factors? \_\_\_\_\_

**Do you experience chronic pain?**

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

What makes it better? \_\_\_\_\_

\_\_\_\_\_

What makes it better? \_\_\_\_\_

\_\_\_\_\_

**Have you had any orthopedic injuries?**

If yes, use the space below to explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Use the space below to tell us about your health history**

(Cancer, Arthritis, Neuropathy, Stroke, Sprains/Strains, Joint Replacements, etc...)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Would you say your relationships are healthy?

With yourself:

☐ Yes

☐ No

With others:

☐ Yes

☐ No

## Have you been emotionally abused?

☐ Yes

☐ No

## Have you been physically abused?

☐ Yes

☐ No

Who do you live with? \_\_\_\_\_

\_\_\_\_\_

What EMF are you exposed to daily? \_\_\_\_\_

\_\_\_\_\_

Hours per day you are interacting with TV, Tablet, Computer or Phone? \_\_\_\_\_

\_\_\_\_\_

What junk food/treats do you use? (Alcohol, Cigarettes, Snacks, etc) \_\_\_\_\_

\_\_\_\_\_

## Are you or have you been exposed to mold?

☐ Yes

☐ No

## Are you or have you been exposed to heavy metals?

☐ Yes

☐ No

## Do you eat organic foods?

☐ Yes

☐ No

How much water, and what kind, do you drink on a good/bad day? \_\_\_\_\_

\_\_\_\_\_

## What are your negative/toxic habits?

Use the space below to explain.

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## What do you do in your spare time?

Use the space below to explain.

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## Do you have any internal pins, wires, artificial joints or special equipment?

What kind, and where?

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Dental History \_\_\_\_\_

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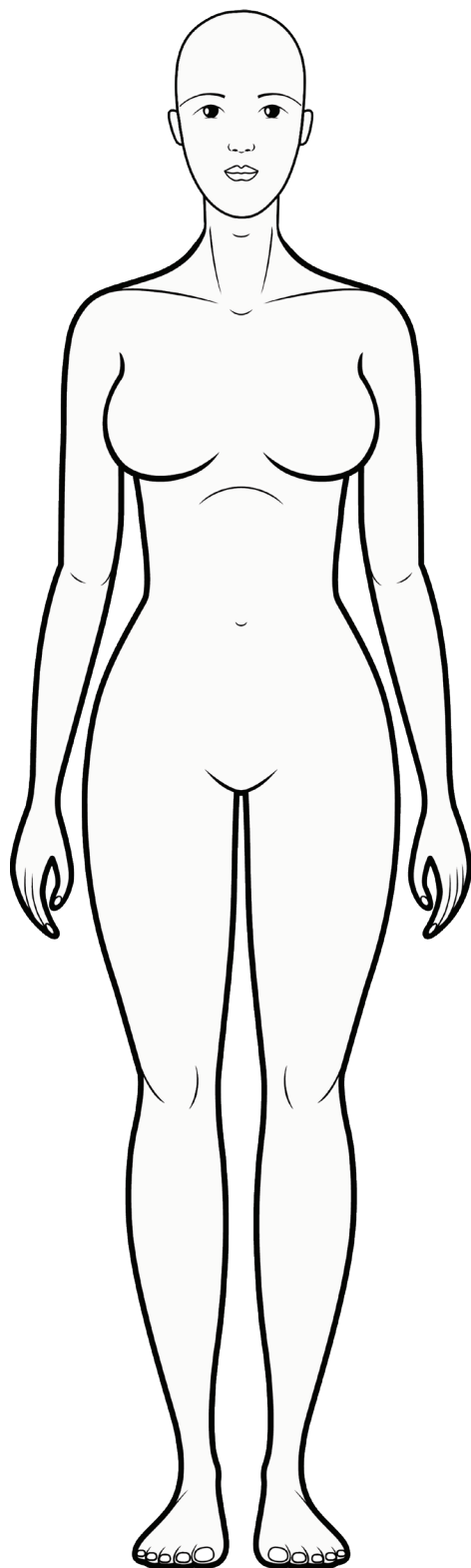
PLEASE FILL OUT STOOL CHART - BE THOUROUGH, THANK YOU

| BOWEL MOVEMENTS         |       |       |       |       |       |       |       |
|-------------------------|-------|-------|-------|-------|-------|-------|-------|
|                         | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| Are you constipated?    |       |       |       |       |       |       |       |
| Do you have diarrhea?   |       |       |       |       |       |       |       |
| Is it uneven formation? |       |       |       |       |       |       |       |
| Is it hard?             |       |       |       |       |       |       |       |
| Is it soft?             |       |       |       |       |       |       |       |
| Is it firm?             |       |       |       |       |       |       |       |
| Is it cracked?          |       |       |       |       |       |       |       |
| Is it smooth?           |       |       |       |       |       |       |       |
| Is it loose?            |       |       |       |       |       |       |       |
| Is it jagged?           |       |       |       |       |       |       |       |
| Stool Length?           |       |       |       |       |       |       |       |

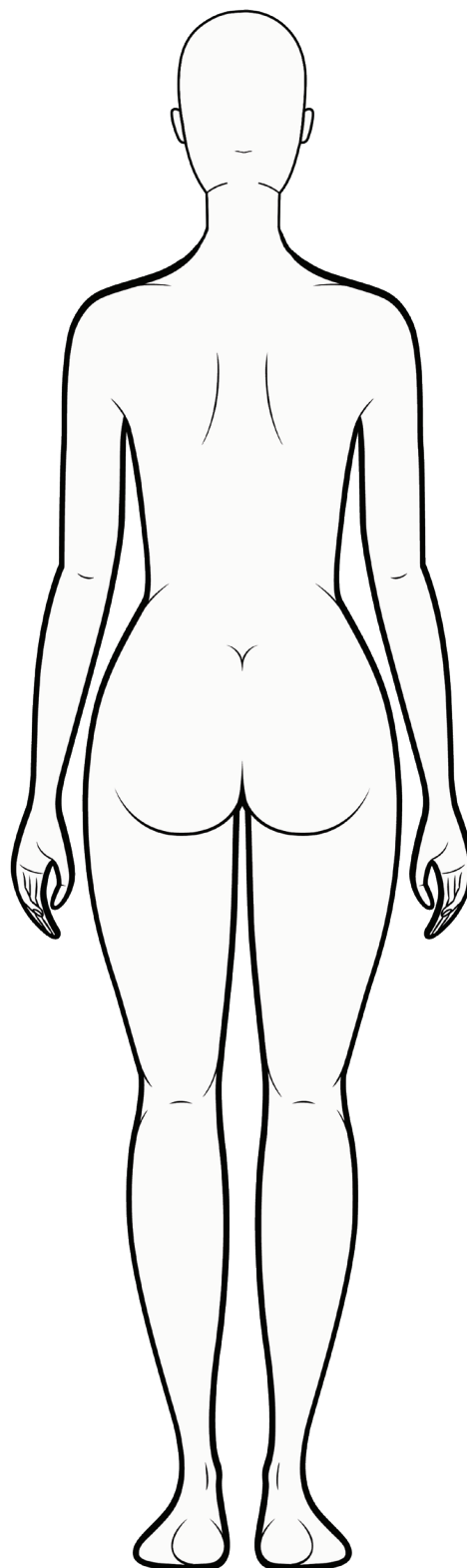
PLEASE FILL OUT STOOL CHART - BE THOUROUGH, THANK YOU

| BOWEL MOVEMENTS                       |       |       |       |       |       |       |       |
|---------------------------------------|-------|-------|-------|-------|-------|-------|-------|
|                                       | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| Stool width?                          |       |       |       |       |       |       |       |
| Does it float?                        |       |       |       |       |       |       |       |
| Does it sink?                         |       |       |       |       |       |       |       |
| Does it have little bubbles in it?    |       |       |       |       |       |       |       |
| Does it have big bubbles in it?       |       |       |       |       |       |       |       |
| Does it contain blood?                |       |       |       |       |       |       |       |
| Does it contain mucus?                |       |       |       |       |       |       |       |
| Does it slide out easily?             |       |       |       |       |       |       |       |
| Do you have to strain?                |       |       |       |       |       |       |       |
| How many bowel movements do you have? |       |       |       |       |       |       |       |
| Time of day?                          |       |       |       |       |       |       |       |

# LIST ALL INJURIES, SURGERIES, AND POINTS OF PAIN ON THE BODY



**FRONT**



**BACK**

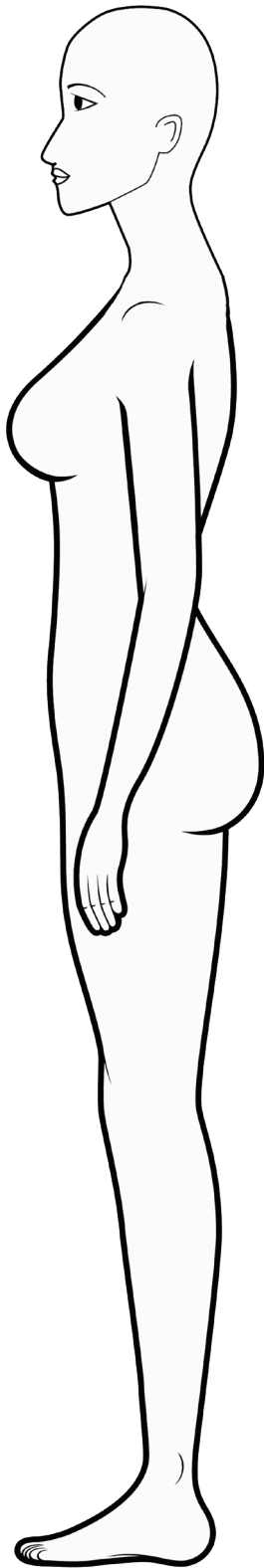
ADHESIONS - A.D.  
FIBROIDS - F.I.  
CRYSTALLIZATION - C.R.

CALCIFICATION - C.A.  
CALCIFIED TUMOR - C.T.  
FATTY TUMOR - F.T.

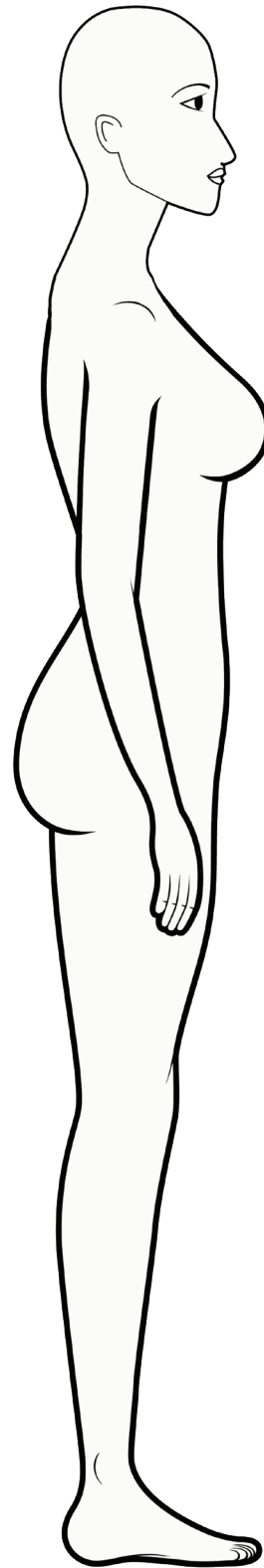
KNOTS - K.  
CYSTS - C.Y.  
SCARS - S.C.



# LIST ALL INJURIES, SURGERIES, AND POINTS OF PAIN ON THE BODY



**LEFT**



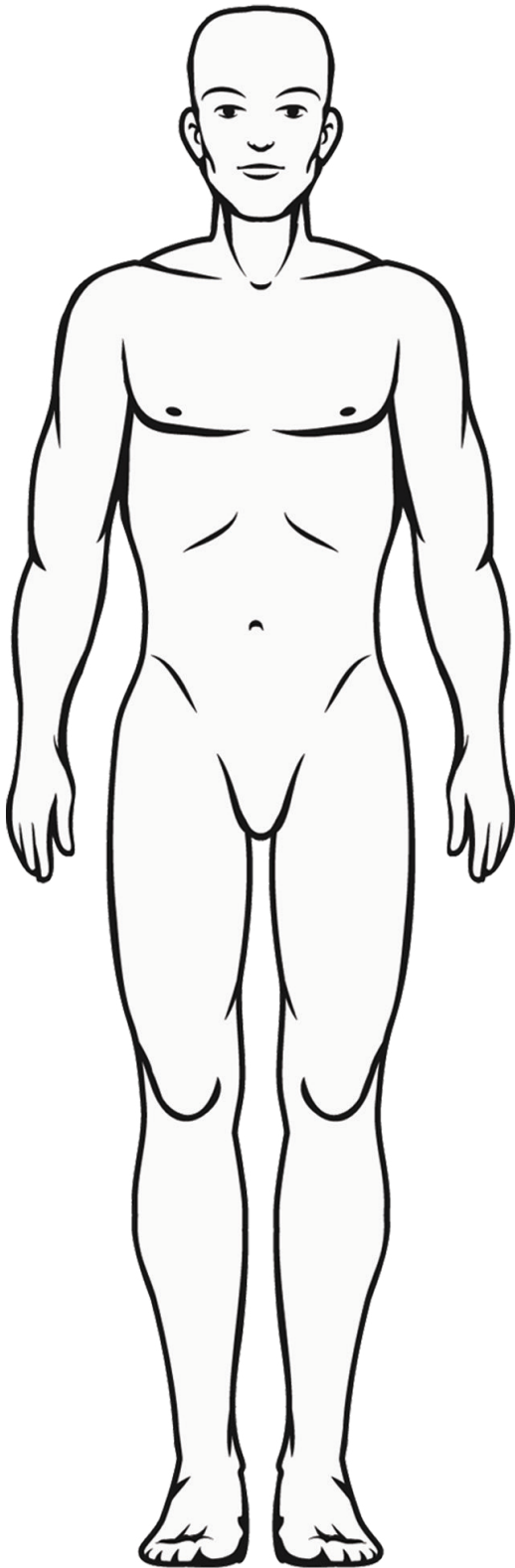
**RIGHT**

ADHESIONS - A.D.  
FIBROIDS - F.I.  
CRYSTALLIZATION - C.R.

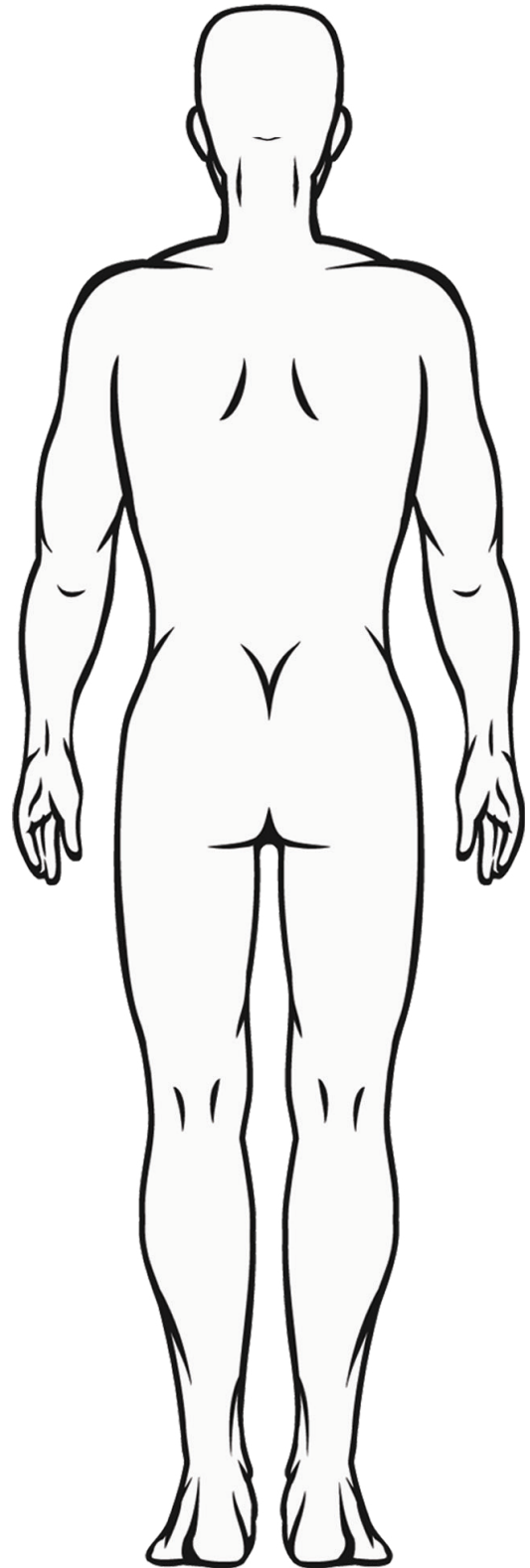
CALCIFICATION - C.A.  
CALCIFIED TUMOR - C.T.  
FATTY TUMOR - F.T.

KNOTS - K.  
CYSTS - C.Y.  
SCARS - S.C.

# LIST ALL INJURIES, SURGERIES, AND POINTS OF PAIN ON THE BODY



**FRONT**



**BACK**

ADHESIONS - A.D.  
FIBROIDS - F.I.  
CRYSTALLIZATION - C.R.

CALCIFICATION - C.A.  
CALCIFIED TUMOR - C.T.  
FATTY TUMOR - F.T.

KNOTS - K.  
CYSTS - C.Y.  
SCARS - S.C.

# LIST ALL INJURIES, SURGERIES, AND POINTS OF PAIN ON THE BODY



**LEFT**



**RIGHT**

ADHESIONS - A.D.  
FIBROIDS - F.I.  
CRYSTALLIZATION - C.R.

CALCIFICATION - C.A.  
CALCIFIED TUMOR - C.T.  
FATTY TUMOR - F.T.

KNOTS - K.  
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