HOLISTIC MEDICAL CLINIC OF THE CAROLINAS

☐HMC ☐WCC ☐NNC ☐FAM ☐CCOC

CASE HISTORY

Name_____ Date_____ Phone_____

Address_____ City_____ State/Zip_____

Age_____ Birth Date_____ Sex_____ Marital Status _____ HT_____ WT_____

Employer_____ Occupation_____ Years at Job_____

Family Physician_____ What was last complaint _____ When_____

Nearest Friend or Relative Who May Be Called in an Emergency: Name Phone_____

How did you hear about our clinic_____

PREVIOUS HISTORY :

☐Measles
☐Scarlet Fever
☐Rheumatism
☐Tuberculosis
☐Asthma
☐HIV
☐Venereal Disease
☐Hives
☐Mental
☐Pneumonia
☐Dizziness
☐Whooping Cough
☐Mumps
Other_____

PREVIOUS HISTORY :

_____
_____
_____
_____
_____
_____

Method of onset _____

How Long Since Well _____ Duration _____

Have you seen another DR. for this_____ When _____ Treatment _____

FAMILY HISTORY :

Father L☐ D☐ Mother L☐ D☐
Brother L☐ D☐ Sister L☐ D☐

☐Rheumatism ☐Cancer ☐Heart Disease
☐Stomach disorders ☐Insanity ☐Asthma
☐Tuberculosis ☐Goiter ☐Diabetes
☐Kidney Disease ☐Other

Operations:

When and Where By Whom

_____
_____
_____
_____

Accidents:

_____
_____
_____
_____

Habits:

Coffee _____ Tea _____ Tobacco _____
Alcohol_____ Medications_____ Laxatives_____
Sleep_____hrs. Work _____hrs.
Exercise _____/wk Bowel Movements _____ /wk

Marital History

Married_____yrs No. Of Children ____ Ages _____
No. Of Pregnancies___ Deliveries ____ Complications ____
Miscarriages_____ Accidental_____ Induced_____

Do you have a living will? ____ Do you want to discuss this? ____

Check Symptoms You Have Noticed

☐Headache ____x/WK
☐Neck Pain
☐Neck Stiff
☐Sleeping Problems
☐Back Pain
☐Nervousness
☐Tension
☐Irritability
☐Chest Pain
☐Dizziness
☐Head Seems To Heavy
☐Pins & Needles In Arms
☐Pins & Needles In Legs
☐Numbness in Fingers
☐Numbness in Toes
☐Shortness of Breath
☐Fatigue
☐Depression
☐Light Bothers Eyes
☐Loss of Memory
☐Ears Ringing
☐Face Flushed
☐Buzzing in Ears
☐Loss of Balance
☐Head Seems To Heavy
☐Fainting
☐Loss of Smell
☐Loss of Taste
☐Frequent Urination
☐Cold Feet
☐Cold Hands

Shoulder L☐ R☐
Arm L☐ R☐
Elbow L☐ R☐
Hand L☐ R☐
Upper Back☐
Mid-Back☐
Lower Mid-Back☐
Lower Back☐
Hip L☐ R☐
Thigh L☐ R☐
Calf L☐ R☐
Knee L☐ R☐
Ankle L☐ R☐
Foot L☐ R☐
Chest L☐ R☐
Above Stomach☐
Below Stomach☐
Gall Bladder☐
Appendix Area☐
Kidney Area☐
Painful Menses☐
Prostate Pain☐
Other Pain In_____
Loss of Weight☐
Diarrhea☐
Increased Thirst☐
Exhaustion.☐
Other Symptoms_____

Authorizing Signature _____

Guardian or Spouse Authorizing Care _____

History by Doctor_____

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Patients Name _____ DOB _____

Drug Allergies and Sensitives

_____

_____

_____

_____

Current Prescriptions Medications:

Prescription Name	Dosage	Frequency	Reason Medication Is Taken
Prescriptions form HMC (Clinic Use Only)			

Supplement	Manufacturer	Dosage/Frequency	Supplement/Dose/Date (Client Use Only)		