

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 _____

FAMILY HISTORY :

- | | |
|---|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Mental |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Venereal Disease | Other _____ |

PREVIOUS HISTORY :

Method of onset _____
How Long Since Well _____ Duration _____
Have you seen another DR. for this _____ When _____ Treatment _____

FAMILY HISTORY :

- | | | |
|---|--|--|
| Father L <input type="checkbox"/> D <input type="checkbox"/> | Mother L <input type="checkbox"/> D <input type="checkbox"/> | |
| Brother L <input type="checkbox"/> D <input type="checkbox"/> | Sister L <input type="checkbox"/> D <input type="checkbox"/> | |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Stomach disorders | <input type="checkbox"/> Insanity | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other | |

Check Symptoms You Have Noticed

- | | |
|---|--|
| <input type="checkbox"/> Headache ____x/WK | Shoulder L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Neck Pain | Arm L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Neck Stiff | Elbow L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Sleeping Problems | Hand L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Back Pain | Upper Back <input type="checkbox"/> |
| <input type="checkbox"/> Nervousness | Mid-Back <input type="checkbox"/> |
| <input type="checkbox"/> Tension | Lower Mid-Back <input type="checkbox"/> |
| <input type="checkbox"/> Irritability | Lower Back <input type="checkbox"/> |
| <input type="checkbox"/> Chest Pain | Hip L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Dizziness | Thigh L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Head Seems To Heavy | Calf L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Pins & Needles In Arms | Knee L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Pins & Needles In Legs | Ankle L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Numbness in Fingers | Foot L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Numbness in Toes | Chest L <input type="checkbox"/> R <input type="checkbox"/> |
| <input type="checkbox"/> Shortness of Breath | Above Stomach <input type="checkbox"/> |
| <input type="checkbox"/> Fatigue | Below Stomach <input type="checkbox"/> |
| <input type="checkbox"/> Depression | Gall Bladder <input type="checkbox"/> |
| <input type="checkbox"/> Light Bothers Eyes | Appendix Area <input type="checkbox"/> |
| <input type="checkbox"/> Loss of Memory | Kidney Area <input type="checkbox"/> |
| <input type="checkbox"/> Ears Ringing | Painful Menses <input type="checkbox"/> |
| <input type="checkbox"/> Face Flushed | Prostate Pain <input type="checkbox"/> |
| <input type="checkbox"/> Buzzing in Ears | Other Pain In _____ |
| <input type="checkbox"/> Loss of Balance | Loss of Weight <input type="checkbox"/> |
| <input type="checkbox"/> Head Seems To Heavy | Diarrhea <input type="checkbox"/> |
| <input type="checkbox"/> Fainting | Increased Thirst <input type="checkbox"/> |
| <input type="checkbox"/> Loss of Smell | Exhaustion. <input type="checkbox"/> |
| <input type="checkbox"/> Loss of Taste | Other Symptoms _____ |
| <input type="checkbox"/> Frequent Urination | _____ |
| <input type="checkbox"/> Cold Feet | _____ |
| <input type="checkbox"/> Cold Hands | _____ |

Operations:

When and Where	By Whom
_____	_____
_____	_____
_____	_____

Accidents:

Habits:

Coffee _____ Tea _____ Tabaco _____
Alcohol _____ Medications _____ Laxatives _____
Sleep _____ hrs. Work _____ hrs. /wk
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 have a living will? _____

Authorizing Signature _____
Guardian or Spouse Authorizing Care _____
History by Doctor _____

