HOPE Wellness Institute
Healing Options for Personal Excellence

CONFIDENTIAL CASE HISTORY

Please Print

Name_____ Home# _____Mobile # _____Work# _____

Email_____ Would you like to be added to our Newsletter? Y ☐ N ☐

Address _____City_____ State _____ Zip_____

Date of Birth (mm/dd/yr) __ __ / __ __ / __ __ __ __ Age:____ Sex: M ☐ F ☐ Marital Status:_____ # of Children: _____

Who is Responsible for this Account?_____ Occupation: _____Referred by_____

1. **PRESENT SYMPTOMS:** What is your major complaint? _____
2. **MINOR COMPLAINTS:** Other areas of pain or concern? _____
3. When did you first notice major complaint? _____
4. What brought it on?_____
5. What activities aggravate condition?_____
6. Is this condition getting progressively worse? Yes ☐ No☐ Constant ☐ Varies ☐ _____
7. Is this condition interfering with your: Work ☐ Sleep☐ Daily Routine ☐
8. What do you believe is wrong with you _____
9. What have you done to get relief? _____
10. Has there been a medical diagnosis? Yes ☐ No ☐ If yes, what was the diagnosis? _____

    By Whom? _____ Phone#_____ City:_____ State:_____
    X-rays_____ Blood work _____ May we contact? _____

PAST HISTORY

11. Have you had a similar problem before? Yes ☐ No ☐ If yes, when?_____What caused those episodes?_____

    What relieved them?_____
12. Did they disable you?_____ Prevent you from working? _____Hospitalized you? _____

    What diagnosis? _____
    What were the treatments? _____ Did the treatments help? _____

Name of attending physician: _____ Address: _____
City: _____ Phone Number: _____ May we contact your physician? _____
Current medications you are taking: _____

Have you ever had any operations? Yes ☐ No ☐ If yes, describe briefly_____

Broken bones? Yes ☐ No ☐ _____

Accidents or injuries? Yes ☐ No ☐ _____

If yes, did you receive a whiplash? _____

Are you taking any of the following?

Habit	Heavy	Moderate	Light	None	Habit	Heavy	Moderate	Light	None
Alcohol					Tobacco				
Coffee					Exercise				
Tea					Sugar				
Water									

Laxatives		Sedatives	
Aspirin		Vitamins	
Sleeping Pills		Minerals	
Insulin		Herbs	

HOPE Wellness Institute

DO YOU HAVE ANY DIFFICULTLY WITH THE FOLLOWING:

Headache		Sinus trouble		Ringing in ears		Wear glasses	
Shooting head pain		Loss of smell		TMJ Pain		Lights bother eyes	
Face flushed		Hay fever		Twitching of face		Fainting	
Head feels too heavy		Loss of taste		Neuritis in shoulders and hands		Loss of memory	
Muscle Spasms in neck		Tightness in throat		Pins and needles in arms & hands		Thyroid trouble	
Grating in Neck		Inflammation of throat		Tightness/pain in shoulders		Cold hands	
Back/low back pain		Painful joints		Pain in groin area		Swollen ankles	
Pinched nerves in back		Swollen joints		Shortness of breath		Cold feet	
Slipped disc		Arthritis		Heart pain		Pains or numbness/tingling in legs / feet	
Chest pains		High blood pressure		Stomach trouble		Rheumatic fever	
Heart palpitations		Low blood pressure		Nervous stomach		Asthma	
Heart attacks		Anemia		Nerves and nervousness		T.B.	
Indigestion		Kidney trouble		Depressions		Diabetes	
Intestinal gas		Bladder trouble		Melancholia of long standing		Ulcers	
Persistent abdominal pain		Gall bladder trouble		Sleeping problems		Cold sweats Excessive perspiration	
Constipation		Liver trouble		Dizziness		Cancer	
Tire too easily		Inner tension		Irritability		Loss of balance	
Fatigue		Osteoporosis		Heart disease			

How many bowel movements daily? _____ Do you have a history of constipation? _____
If yes, what have you done to relieve it? _____

Age of mattress? _____ Comfortable? Yes☐ No☐ Bedboard? Yes☐ No☐ Use a foam pillow? Yes☐ No☐ Sleep on: Side☐ Back☐ Stomach☐

Are you wearing: Heel lifts☐ Sole lifts☐ Arch supports☐ Inner soles☐

I understand that the therapists at HOPE Wellness Institute are not doctors, and therefore cannot diagnose. I understand that 24 hour notice needs to be given in the event of a cancellation, otherwise I will be charged for the whole session I booked for. I am responsible for any outstanding balances on this account. If needed, I hereby authorize Release of Records to: HOPE Wellness Institute, that my Health Care Provider/Facility may release any and all of my medical information for my benefit. If needed, I give permission to my therapist to share my file and to discuss my needs to his or her co-workers at HOPE Wellness Institute. All of the above has been answered to the best of my knowledge.

Signature _____ Date: _____

THERAPIST NOTES: