PEAK PERFORMANCE
Health Center

CONFIDENTIAL CASE HISTORY

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ POSTAL CODE:_____

EMAIL:_____

TELEPHONE: HOME:_____ CELL/WORK:_____

OCCUPATION:_____

HOW DID YOU HEAR ABOUT THE CLINIC:_____

DOCTOR:_____ PHONE:_____

INSURANCE CO:_____

HEALTH HISTORY

CHIEF COMPLAINT: _____

AGGRAVATED BY:_____ RELIEVED BY:_____

HAVE YOU RECEIVED ANY OTHER FORMS OF TREATMENT FOR THIS CONDITION?_____

PAST SURGERIES:_____

CURRENT MEDICATIONS:_____

DATE OF INJURY/ACCIDENT:_____ TYPE OF INJURY:_____

DO YOU HAVE ANY METAL IMPLANTS, PINS, WIRES, ARTIFICIAL LIMBS, ETC?:_____

GOOD SLEEPING PATTERNS: YES □ NO □

IT IS IMPORTANT FOR ME TO KNOW YOUR HEALTH HISTORY. PLEASE CHECK IF YOU HAVE OR RECENTLY HAD ANY OF THE FOLLOWING:

HEAD AND NECK

___HEADACHES: TYPES_____
___VISION PROBLEMS
___GLASSES/CONTACTS
___EARACHES
___SINUS PROBLEMS
___FREQUENT COLDS
___OTHER _____

CARDIOVASCULAR

___HIGH/LOW BLOOD PRESSURE
___CHEST PAIN
___DIZZINESS/FAINTING
___HEART ATTACK/STROKES
___ADVANCED ARTERIOSCLEROSIS
___PHLEBITIS/VARICOSE VEINS
___HEMOPHILIA

SKIN

___CONTAGIOUS SKIN DISEASE
(IE: ATHLETE'S FOOT, PLANTAR WARTS)
___OPEN SORES/WOUNDS/BOILS
___BRUISES EASILY
___SENSITIVE SKIN
___INFECTIOUS DISEASE
___OTHER:_____

MUSCLES AND JOINTS

___PAIN ___STIFFNESS
___SWELLING ___CRAMPS
___LIMITATION OF MOVEMENT
___POOR POSTURE
___BACK PAIN ___NECK PAIN
___SHOULDER PAIN
___ARTHRITIS TYPE_____

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RESPIRATORY

___SMOKING
___CHRONIC COUGH
___SHORTNESS OF BREATH
___CHEST PAIN
___ASTHMA
___BRONCHITIS
___EMPHYSEMA
___OTHER _____
___DIABETES
___ULCERS

DIGESTION

___CONSTIPATION
___DIARRHEA
___GAS
___NAUSEA
___LIVER/GALL BLADDER
___LIVER DISEASE
___ALCOHOL CONSUMPTION
___LIGHT ___HEAVY
___HYPOGLYCEMIA
___OTHER DIGESTIVE DISORDERS

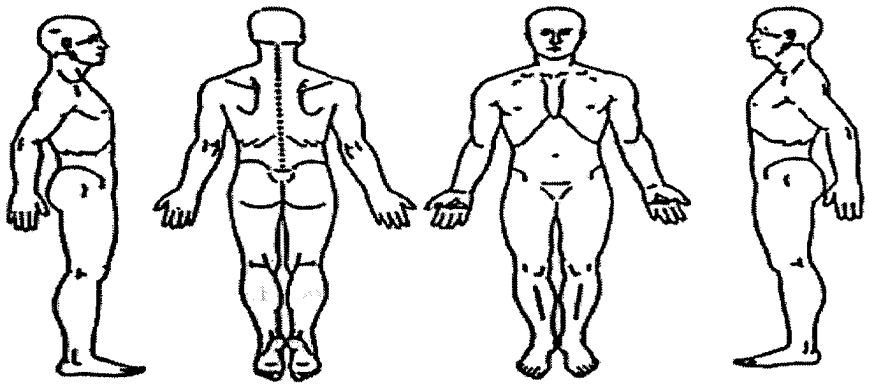
ABDOMINAL

___HERNIA
___COLITIS ___HEPATITIS
___DIVERTICULITIS
___CHROHN'S DISEASE
___GASTRITIS
___KIDNEY AND BLADDER PROBLEMS
___FREQUENT URINATION
___ADVANCED KIDNEY DISEASE
___AIDS OR HIV POSITIVE

SPECIAL NOTES

___PINS ___PLATES ___WIRES
___PROSTHESIS: TYPE:_____
___NEUROLOGICAL DISORDER
___HORMONAL DISORDER
___CANCER: TYPE:_____
___TUMORS
___UNDIAGNOSED LUMPS
LOCATIONS:_____

PLEASE CIRCLE AREAS OF DISCOMFORT



CONSENT FOR ASSESSMENT AND TREATMENT

I, (print) _____ consent to be assessed and treated at Complete Physical Wellness starting _____. I understand that at any time I have the right to refuse or stop treatment.

SIGNATURE:_____ DATE:_____