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 _____

PRESENT COMPLAINT OR ILLNESS:

_____
_____
_____
_____
_____
_____
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 ____
Brothers L ____ D ____ Sisters L ____ D ____
____Rheumatism ____Cancer ____Heart Disease
____Stomach disorders ____ Goiter ____ Asthma
____Tuberculosis ____ Insanity ____ Diabetes
____ Kidney Disease ____ Other

OPERATIONS:

When and Where By Whom

_____
_____
_____
_____

ACCIDENTS:

_____
_____
_____
_____

HABITS:

Coffee _____Tea _____ Tobacco _____
Alcohol _____Medications _____ Laxatives _____
Work _____hrs. Sleep _____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 wish 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
___ FAINTING
___ LOSS OF SMELL
___ LOSS OF TASTE
___ FREQUENT URINATION
___ COLD FEET
___ COLD HANDS
___ UPSET STOMACH
___ CONSTIPATION
___ COLD SWEATS
___ FEVER

PAIN IN:
SHOULDER R__ L __
ARM R__ L __
ELBOW R __ L __
HAND R __ L __
UPPER BACK ___
MID-BACK ___
LOWER –MID BACK ___
LOWER BACK ___
HIP R __ L __
THIGH R __ L__
CALF R __ L __
KNEE R __ L __
ANKLE R __ L __
FOOT R __ L __
CHEST R __ L __
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 _____

Holistic Medical Clinic of the Carolinas: 5) ________________ 6)________________

1) ________________ 2) ________________ 3) ________________ 4) ____________

	Today	Next	Completed
___ HMC Intro.			
___ Chem. (male / female)			
___ G6PD			
___ Ca Markers			
___ CBC / Differential			
___ Arthritis Panel			
___ HgbA1C			
___ Heavy Metal Test			
___ ALCAT			
___ Anti-Aging Hor.			
___ Allergy Panel (Ig __)			
___ CDSA			
___ Live Cell			
___ Vitamin D			
___ 2:16 Ratio			
___ White Oak Form			
___ Clean Room Form			
___ Age Test			
___ 7 Day Food Log			
___ Yeast Review			
___ Adrenal Review			
___ Hormone Review			
___ Mental / Stress Test			
___ Ankle / Brach Index			
___ Vascular Exam			
___ Surgical Consult			
___ Gyn. Exam			
___ MRI / CT / US ____			
___ DEXA Scan			
___ X-ray Area: ____			
___ Nutritional Consult			
___ Acupuncture			
___ Reflexology / MST			
___ Manipulation			
___ Chelation			
___ Colonic Irrigation			
___ I.V. Therapy x			
___ PICC line / Port			
___ Injection B-12			
___ Injection ______			
___ Colon / Sigmoidoscopy			
___ Barnes Basal Temp.Test			
___ Nutritional Screening			
___ Charcoal Test			
___ Ear Lavage			
___ Ragland Testing			
___ Iodine Patch			
___ Thermogram			
___ Wt. Loss Consult / Diet			
___ Will preparation			
___ Horm. Consult			
___			
___			

___ Refer - Dr. For:

Patient Name ______________________________ **DOB** ______________

Drug Allergies and Sensitivities:

____

____

____

____

Current Prescriptions Medications:

Prescription Name	Dosage	Frequency	Reason medication Is taken
Prescriptions from HMC (Clinic Use Only)			

Supplements:

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