Name: ______________________________________ Date: __________________

Confidential Patient Case History: Part of your permanent record.

Please complete this questionnaire. Initial the bottom of each page when it is completed. *Thank you!*

We read and pay attention to every answer!

The questionnaire is lengthy! There are two reasons why:

- Health care law and insurance companies require that we collect several pieces of data for the administrative process.
- The better we understand you, the more we can help you.

Contact and Demographic Information

Last Name: ____________________________ First Name: ___________________________ MI: _____

Nickname/What do you like to be called? ____________________________________

Street Address: ______________________________________ Unit #: _________

City: _______________________ State: ________ Zip: ________

Neighborhood (City of Chicago only): _____________________________________

Email Address: ____

Home Phone: _________________ Work Phone: _________________ Cell Phone: _________________

Best number to contact you: _____ Home _____ Work _____ Cell

Date of Birth: ________________________ Age: ______ Social Security Number: _____________________

Sex: _____ Male _____ Female _____ Other

Occupation: ____________________________ Employer: _________________________________

Marital Status: ___Married ____Partnered ____Single ____Divorced ____Separated ____Widowed ___Other

Children (Name/Age/Sex): ____

Spouse's Name: ____

Emergency Contact Information

Emergency Contact: ___________________________ Relationship: ___________________________

Emergency Contact Home Phone: _________________ Emergency Contact Cell Phone: _______________

Information about your journey to our office

How did you hear about UHI? Who referred you to us? ____________________________________

How did you travel to UHI? Car Bus Train Cab Bike Walk

Information about your experience with natural health care

Have you used natural health care before? Yes No

Below is a list of therapies offered at UHI. Please mark any services you have previously experienced.

___ Chiropractic Care ___ Acupuncture/Chinese Medicine ___ CranioSacral Therapy

___ Physical Therapy ___ Energy Therapy/Reiki ___ Counseling and coaching

___ Massage Therapy ___ Nutrition Therapy

Did you have a good experience with the therapies you have used? Please let us know.

____

Name: ______________________________________ Date: ____________________

What is the reason for your visit today? Check all that you are aware apply to you. (Your body, Your mind) These questions focus on where to start your exam and how we can best help you.

___ Pain/Physical Problem	*(anywhere in your body)*
___ Pregnant	(please fill out the **'Pregnancy Questions'** section on page 5)
___ Chemical/Metabolic Condition	Example: digestive trouble, sleeplessness, something not best described as 'pain' (please pay special attention to the **'Metabolic Screen Questionnaire'** on page 12)
___ Mental Stress/Emotional Pain or Challenge	(please pay special attention to the **'Stress Strategies Screening Questionnaire'** on page 13)

Describe the main problem you would like us to help you with today

1. If we could help you with **one** health problem today, what would it be? ______________________________

____

2. How many days out of the week or month do you find yourself suffering from this problem?

_____ Every day _____ Every other day _____ Several days (2, 3, 4, 5, 6) days per week/month

3. How long will it last on a bad day? ____

4. When did this problem begin? (month/year) ______________________________________

5. Have you had this or a similar problem in the past? Yes No

If yes, please describe: ____

6. Has the problem been getting worse over time? Yes No

7. What do you think makes this problem worse? ______________________________________

8. When the probem is at its worst, exactly what does it feel like? ______________________________

____

9. Many people tell us that their condition makes them feel upset or older than they are.

Have you experienced this? Yes No How does it make you feel? ____________________

10. Answer the following questions using a scale of 0-10, with 10 being the worst, 0 being ideal.

How would you rate this problem *right now* ?

0 1 2 3 4 5 6 7 8 9 10

How would you rate this problem in the *last week* ? (What is your average/typical rating for the problem?)

0 1 2 3 4 5 6 7 8 9 10

How would you rate this problem *at its best* ? (How close to 0 does the problem get?)

0 1 2 3 4 5 6 7 8 9 10

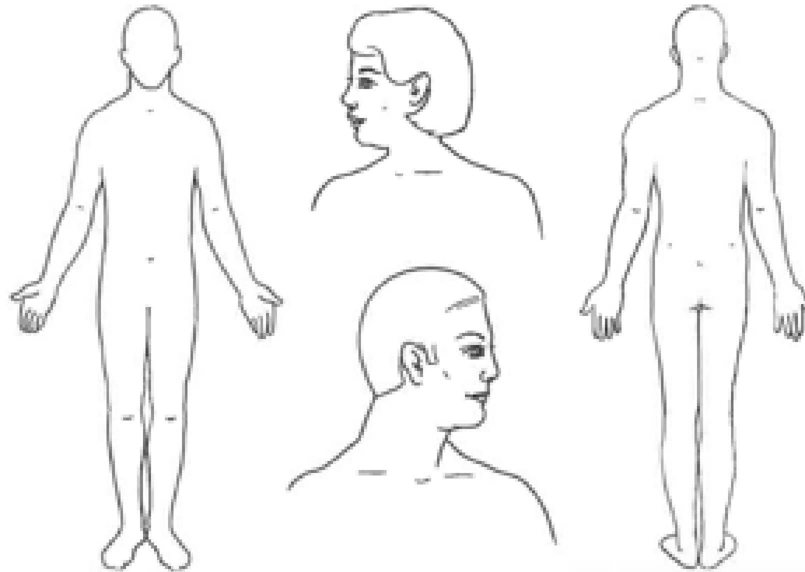
How would you rate this problem *at its worst* ? (How close to 10 does the problem get?)

0 1 2 3 4 5 6 7 8 9 10

Name: ____ Date: ____________________

Mark the areas of your symptoms on the figures below. Use the following symbols to describe them:

Aches ++++++ Numbness ***** Pins/Needles ----- Stabbing /////



Describe what caused this problem

Do you think a specific accident/injury/trauma/habit/life event/medication caused this problem?

Yes No If yes, what was it? ____

Describe how you have tried to manage this problem

Since the time you have been suffering from this problem, what have you tried as a remedy or cure? (check all that apply)

___ Ice	___ Stretching	___ Change in diet	___ Concentrating
___ Heat	___ Massage	___ Change in habits	___ Acupuncture
___ Rest	___ Prescription meds	___ Avoiding activities	___ Prayer
___ OTC* medication	___ Doctor advice	___ Changing activities	___ Meditation
___ Physical therapy	___ Ignoring it	___ Limiting activities	___ Wishing
___ Exercise	___ Sleep	___ Nutrition	___ Waiting

Other: ____

*OTC Over the Counter

Have any of these given you relief? Yes No

If yes, what has given you the most relief? ____

Have you done anything to fix this problem and not simply relieve the symptoms? Yes No

If yes, what was it? ____

Name: ______________________________ Date: ________________

Describe how this problem is affecting you

1. What activities does this problem prevent you from doing, either partially or completely, that you would enjoy doing again if you did not have this problem or condition? ______________________________

____

2. How does this problem prevent you from doing these things? ______________________________

____

3. What areas of your life is this problem affecting? (check all that apply)

___ My work	___ My family life	___ My appetite
___ My attitude	___ My enthusiasm	___ My interest in others
___ My social activities	___ My finances	___ My personal hygiene
___ My ability to rest	___ My ability to concentrate	___ My hobbies
___ My sports/exercise	___ My productivity	___ My personal life
___ My intimacy	___ My vitality	___ My mood
___ My digestion	___ My sexuality	Other: ______________

5. Has this problem affected your sleep patterns? (check all that apply)

______ Trouble falling asleep ______ Awakening in the middle of the night

______ Not enough restful sleep ______ Waking earlier than normal

Other: ______________________________

6. Have you become discouraged about this problem? Yes No

7. If you are not discouraged, does it concern you that this problem persists? Yes No

Why does it concern you? ______________________________

8. Are you concerned that it will not go away or it will get worse in the future? Yes No

9. How often do you keep a positive attitude?

_____ Most of the time _____ Some of the time _____ Not very often _____ Hardly at all

10. If you do not resolve this problem, where do you think you will be in five years? ______________

____

Are you ready to take care of this problem?

Taking into consideration what you have described so far, do you feel you need to change the way you have been dealing with this problem? Yes No

On a scale of 0 to 10, with 10 being all in and 0 being no interest, how would you rate your commitment to solving this problem?

0 1 2 3 4 5 6 7 8 9 10

Is there anything preventing you from solving this problem? Yes No If yes, please describe:

____

____

Thank you for this information. For most of our patients, this is a marathon not a sprint. However, we will do something therapeutic today to help you feel better!

Universal Health Institute
One East Erie St. Suite 450 Chicago, IL 60611

Patient Initial _____
Clinician Initial _____

Name: ____ Date: ____________________

Pregnancy Questions

Please check here if this section does not apply: _____

How many weeks pregnant are you? ___________________ When is your due date? _______________________

Is your baby in a breech position? Yes No

Do you have any of the following procedures scheduled (please circle and indicate date):

C-section ______________ ECV ______________ Induction ______________

Did you conceive naturally or with the help of fertility experts? ____________________________________

If with fertility experts, how stressful was that experience?

Please rate your experience, using a scale of 0 – 10, with 10 being most stressful:

0 1 2 3 4 5 6 7 8 9 10

Not Stressful at all --Extremely Stressful

How would you rate your pregnancy so far? Please rate, using a scale of 0 – 10, with 10 being difficult:

0 1 2 3 4 5 6 7 8 9 10

Easy--Difficult

Do you feel you have gained the adequate amount of weight? Yes No If no, explain: ______________________

Are you taking prenatal vitamins? Yes No If yes, when did you start? ____________________________________

Do you have a Birth Plan? Yes No If yes, what is it?____

Are you using a Doula to support/assist you in Labor and Delivery? Y N If yes, whom? ___________________

Pregnancy/Past pregnancy/Labor/Delivery/Post-partum information: (check all that apply)

____ Uncomplicated vaginal delivery
____ Complicated vaginal delivery
Explain: ______________________________
____ C-Section
____ Induction
____ Episiotomy
____ Vaginal tearing
____ Gestational diabetes
____ Varicose veins
____ Pre-Eclampsia/Eclampsia
____ Incontinence
____ Weight gain
____ Hashimotos Thyroiditis
____ Autoimmune condition
____ Metabolic change
____ Depression
____ Decreased sex drive
____ Other: ______________________________

Any unusual shape of or history having to do with your uterus or cervix? Yes No Explain: _______________

Do you have concerns about any of the following? (check all that apply)

____ Labor and Delivery
____ Changes in family dynamic
____ Adding a first child to the family
____ Adding another child to the family
____ Adding another child too quickly to the family
____ Coping with working and having a child
____ Finding proper child care
____ Having enough support from family and friends
____ Post-Partum conditions
____ Being a single parent
____ Changed finances with the expanding family
____ My physical health
____ My mental health
____ Not having a strategy for increased stress
____ Losing sleep from baby waking

Name: ____ Date: ____________________

Pregnancy Questions cont.

Do you plan to breast feed? Yes No If yes, for how long do you plan to breast feed? ____________________

Have you breast fed in the past? Yes No If yes, for how long did you breast fed? ____________________

If no, what challenges did you face/what prevented you from breastfeeding? ____________________

Do you plan to use formula? Yes No If yes, what type of formula do you intend to use? ____________________

Are you interested in learning more to support your experience of labor, delivery, motherhood, or parenting: (check any that apply)

____ Birth plan/Choices at the hospital
____ Hypnosis/Relaxation for labor
____ Induction
____ C-section
____ Bonding with baby
____ Safe methods for handling baby's early colds/viruses
____ Infant massage to help baby rest and sleep better
____ Post-partum care
____ Preventing incontinence
____ Stretch marks
____ Body image
____ Losing weight

The team at UHI is here for you during and after your pregnancy. We can help with many of your concerns!

Name: ______________________________ Date: ______________

Other problems that have bothered you in the past six months

Other than what you have described so far, do you have or have you had any other problems/concerns/conditions/complaints/sources of stress?

This could include something that is affecting you physically/structurally, chemically, or mentally.

Please list them here and include the last time you experienced each problem:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Prescribed and Over-the-Counter Medications

Do you take any prescribed or OTC medications? Yes No

What do you take? How long have you taken this?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Who is managing these medications? ______________________________

Is one of your goals to reduce the number of medications you are taking? Yes No

If yes, which medications do you wish to reduce or eliminate? ______________________________

How many times in your life have you been on antibiotics? ______________________________

Nutritional Supplements/Herbal Therapy

Do you take any nutritional supplements or herbal therapy? Yes No

What do you take? How long have you taken this?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Who is managing these supplements? ______________________________

Are there any supplements you are interested in learning more about to support your health?

____

Name: ______________________________________ Date: ____________________

Lifestyle Information Habits

Current weight: _______________ Height: _______________

Have you lost or gained weight in the last 6 months to 1 year (for a reason other than pregnancy)? Yes No

If yes, how much? __________ Did you lose/gain it intentionally? Yes No

Work and Exercise intensity: (indicate for each category)

Mental Work: Heavy Moderate Light _______hrs/day, _______days/week

Physical Work: Heavy Moderate Light _______hrs/day, _______days/week

Exercise: Heavy Moderate Light _______hrs/day, _______days/week

Sleep: Weekdays _______ hours/night Weekends _______ hours/night

Cigarette Smoking: Current: Yes No _______packs/day _______years

Past: Yes No _______packs/day _______years

Alcohol use: _______ Beers/week _______Wine/week _______ Liquor/week for _______years

Caffeine Use: _______ Coffee/day _______Tea/day for _______years

Pop/Soda intake: ______ /day for _______ years; ______ Diet _______ Regular

Sweets consumption: _____ /day for _______ years; Type of sweets consumed: ______________________________

Aspirin Use _______ Aspirin/day _______years

OTC Pain Killers: _______ /day _______ years ______ as needed Type of pain killer: __________________________

Nervous/compulsive habits: Yes No Explain: ____

Are you interested in changing any of these lifestyle choices or habits? Yes No

If so, which ones? ____

If you take any other non-prescribed drugs or recreational substances, please let us know during your initial consult.

Name: ______________________________ Date: ______________

Doctor Visits

Do you have a family physician? Yes No What is the name of your doctor? ______________

Hospital affiliation (please circle): Northwestern Rush Advocate UIC Univ. of Chicago Other: ______

Do you see this doctor each year? Yes No Last visit with this doctor? ______________

Are you satisfied with the care you have received from this doctor? Yes No

Do you see any specialists? Yes No

Circle any of the following specialists you see. If circled, please give their name.

Orthopedic Neurologist Pulmonalogist Cardiologist Oncologist Dermatologist Psychiatrist

Other: ____

Specialist's names: ____

Women Doctor Visits

What is your obstetrician/gynecologist's name? ______________________________

Hospital affiliation (please circle): Northwestern Rush Advocate UIC Univ. of Chi. Other: ______

Do you see this doctor each year? Yes No Last visit with this doctor? ______________

Are you satisfied with the care you have received from this doctor? Yes No

Number of pregnancies? ____

Past Diagnoses/History

Have you ever been diagnosed with a disease? Yes No What is it? ______________

Have you ever been diagnosed with any cancer? Yes No What is it? ______________

If yes, how was the cancer treated? (please circle) Chemotherapy Radiation Surgery Other

Have you ever had a stroke? Yes No

Do you have high or low blood pressure? Yes No Please specify: ____ High ____ Low

Have you ever suffered from alcoholism? Yes No

Have you ever suffered from a drug addiction? Yes No

Have you ever had an eating disorder? Yes No

Have you had surgery of any type? Yes No

Have you been diagnosed with osteoporosis or osteopenia? Yes No

Are you concerned about any of the above? ______________________________

Name: ______________________________ Date: ____________________

Family History

List what you know about the health, sickness, disease, or death of the following relatives:

	Age if living	State of health	Age at death	Cause of death
Mother:				
Father:				
Sister(s):				
Brother(s):				
Maternal Grandmother:				
Maternal Grandfather:				
Paternal Grandmother:				
Paternal Grandfather:				

Please rate your family's reaction to illness growing up on a scale from 0-10.

0 1 2 3 4 5 6 7 8 9 10

0=Stoic 3=Nonchalant 5=Reasonable 7=Overconcern 10=Panic

Did your family utilize natural or alternative health care? Yes No

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Patient Intitial _____
Clinician Initial _____

Name: ____ Date: ____________________

Trauma History

Telling us about any trauma your body has suffered in the past is important to helping us help you. A trauma may be obvious or non-obvious. A trauma to your body could have happened last week, ten years ago, when you were three years old, during the birth process, or in utero prior to birth. Please note that body trauma is most often related to a physical event, but may also be related to a chemical, mental, or stress related event. (please check any that apply)

Obvious body trauma

___ Car accident
___ Bike/Roller-blading accident
___ Ski accident
___ A bad or multiple sprain/strain
___ Sports injury or accident
___ A fall that may have caused injury to your spine (even as a child)
___ Fracture/Broken bone/Stress fracture
___ Being struck with an object
___ Something that made you bleed
___ Recreational injury
___ A childhood injury or accident
___ A time when someone thought you were 'really hurt'
___ Injury while moving (home/work)
___ Surgery, **any type** (list below)

Non-obvious body trauma

___ Sleeping in a strained position
___ Sitting at a poor work station
___ Repetitive movements related to work (mouse use, phone use, etc.)
___ Repetitive movements related to sports (tennis, golf, baseball, swimming, etc.)
___ Movements related to playing an instrument
___ Small falls related to youth sports
___ Repeated carrying of heavy bag
___ Long-term period of being over-weight
___ Pregnancy or pregnancies too close together
___ Your own birth with forceps or difficult labor/delivery
___ Use of a drug that caused a reaction/extended use of a drug (including birth control)
___ Prolonged use of an antibiotic, antiviral, anticancer, or antinflammatory drug
___ Repetative corticosteroid shots
___ Mental trauma (Due to death of a loved one, divorce, money addiction, bankruptcy, miscarriage, broken heart, abuse, etc.)

Please list specific traumas to your body, and include a brief description and the year of each event:

____
____
____
____

Name: ____________________ Date: ____________

Metabolic Screen Questionnaire

Which of the following have you experienced in the last six months? (check all that apply)

Please circle any issue that concerns you or seems to be chronic or severe.

______ 1. Unsatisfied with function of intestines, that may include bloating, constipation, incomplete evacuation or diarrhea.

______ 2. Unpredictable food reactions.

______ 3. Sensitivity to environments (any or all: chemicals, cosmetics, sounds, lights, odors, temperature changes).

______ 4. Nails changing, breaking, splitting, spots or fungal infections.

______ 5. Cracking and/or reddened heels or palms.

______ 6. Stomach pain relieved by eating.

______ 7. Stomach pain within 1-4 hours after eating.

______ 8. Heartburn, indigestion, burping.

______ 9. Sensitivity to fatty foods, greasy foods.

______ 10. Fatigue after meals.

______ 11. Crave sweets.

______ 12. Difficulty losing fat.

______ 13. Wake up tired even after 6 or more hours of sleep.

______ 14. Excessive perspiration.

______ 15. Thinning of hair anywhere on body.

______ 16. Skin dryness.

______ 17. Foot pain.

______ 18. Mental sluggishness.

______ 19. Heart palpitations.

______ 20. Inner trembling.

______ 21. Insomnia.

______ 22. Night sweats.

______ 23. Diminished feeling of vitality.

______ 24. Hormonal troubles.

______ 25. Nausea or vomiting.

______ 26. Foul smelling stool.

______ 27. Frequent urination.

______ 28. Increased thirst or appetite.

______ 29. Bitter taste in mouth.

______ 30. Itchy skin.

______ 31. Acne.

______ 32. Light-headed if meals missed.

______ 33. Poor memory.

______ 34. Blurred vision.

______ 35. Diminished sex drive.

______ 36. Leg twitching.

______ 37. Loss of appetite.

______ 38. Sinus pain.

______ 39. Seasonal allergies.

______ 40. Headaches of any kind.

How many times do you typically eat per day? ______

What time do you typically wake up in the morning? __________ What time is your first meal? ___________

What are three healthiest foods you eat? ____________________

What are three un-healthiest foods you eat? ____________________

How many times during the week do you eat the following foods?

Dairy _______ Corn _______

Wheat/White Flour _______ Sugar _______

Soy _______ Alternative Sugar/Sugar Substitute _____ Type: ______________

If you have checked more than 10 of the above questions, please fill out our full Metabolic Assessment Form. Please also let us know if you are interested in further nutrition conseling.

Universal Health Institute
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Patient Initial _____
Clinician Initial _____

Name: ______________________________ Date: ________________

Stress Strategies Screening Questionnaire

This questionnaire is used to recognize and identify the strategies you use to handle stressful challenges in your life. You might use the statements below to describe yourself or your situation. Read each statement below and determine to what degree it describes you or fits your experience. Score the sentence based on your emotional experience, *not using judgment* . Some of the sentences refer to relationships; relationships may include close friends, parents, or a romantic relationship. Look at each statement and score it based on the first person that comes to your mind.

Using the Answers Table, rate the statements below with the score that reflects how accurately the statement describes you.

Answers Table

1 = Completely untrue of me	**3 = Slightly more true than untrue**	**5 = Mostly true of me**
2 = Mostly untrue of me	**4 = Moderately true of me**	**6 = Describes me perfectly**

1. _____I really miss having someone relate to me with warmth and affection, or who really understands me.
2. _____I feel like I really need people to be close to me, but I fear I will lose them, so I often cling to them.
3. _____It is hard for me to feel like I can let my guard down with people. My sense is they often betray others.
4. _____I often feel as though I am really different from other people and do not really fit in.
5. _____If someone really knew the inner me (or the truth about me), they would not like me.
6. _____Other people are much better at handling most tasks in life than I am.
7. _____I need help from others to manage most things in life.
8. _____I am worried that some type of problem: financial, medical, or even becoming a crime victim, will happen to me.
9. _____I often feel as though my life is so involved with others, I do not have a life of my own.
10. _____If I do not do what others want of me, there will be negative results.
11. _____Most of the time my life is focused on other people and their needs.
12. _____I feel as though I must control my feelings; most people do not know how I feel about things.
13. _____I really feel I have to be the best, it is hard for me to make mistakes or just be “good enough”
14. _____I feel that most rules are meant for others, I hate to be kept from doing what I want.
15. _____If a goal is not interesting or a task enjoyable, I lose interest easily or just do not do it.
16. _____I feel most worthwhile when others notice my accomplishments.
17. _____If something positive occurs, it is only natural to think that something negative will happen.
18. _____If something goes wrong and it is my fault, I should suffer the consequences.

If you have scored yourself with many 4's or even one or two 5's and 6's, you could benefit from counseling to help with your stress strategies. Would you like to feel more calm? Would you like better stress strategies? Ask us for your overall score on this screening and how we might be able to help you!