INTEGRATED
HEALTH CARE

SCIENCE - MIND - HOLISTIC

CONFIDENTIAL CASE HISTORY

Please answer all questions as all information is relevant to this assessment

SECTION 1 — PERSONAL DETAILS		
NAME.	EMAIL.	
ADDRESS.		
PHONE (HOME).	PHONE CELL.	PHONE (WORK).
DATE OF BIRTH.	AGE.	NUMBER OF CHILDREN.
OCCUPATION.		REFERRED BY.

SECTION 2 — HEALTH HISTORY		
WHAT IS YOUR MAJOR COMPLAINT/S.		
WHEN DID THIS COMPLAINT START? ☐ WEEKS _____ ☐ MONTHS _____ ☐ YEARS _____		
ISSUE OCCURRED PREVIOUSLY?	WHEN WAS THE FIRST OCCURRENCE?	
IS YOUR COMPLAINT. ☐ CONTINUOUS ☐ OFF AND ON ☐ NEITHER		
HOW DID THIS COMPLAINT OCCUR? ☐ GRADUALLY ☐ SUDDENLY ☐ FROM AN INJURY ☐ AT WORK		
WHAT WAS THE CAUSE OF THE COMPLAINT?		
HAVE YOU SOUGHT TREATMENT FOR THIS COMPLAINT? ☐ YES ☐ NO / IF YES, WHO?		
HOW SUCCESSFUL WAS PREVIOUS TREATMENT?		
LIST ANY OTHER SIGNIFICANT COMPLAINTS.		
INDICATE ANYTHING THAT AGGRAVATES YOUR COMPLAINT.		
LIST ANY TESTS YOU HAVE HAD IN RELATION TO YOUR HEALTH (X-RAYS, BLOOD TESTS ETC).		
INDICATE ALL MEDICATIONS YOU ARE CURRENTLY TAKING. ☐ SLEEPING PILLS ☐ PAIN KILLERS ☐ MUSCLE RELAXANTS ☐ BLOOD PRESSURE MEDS ☐ TRANQUILIZERS ☐ INSULIN ☐ BIRTH CONTROL ☐ ASTHMA MEDS ☐ ANTI-INFLAMMATORIES OTHER:		
LIST ALL BLOOD TESTS RECENTLY COMPLETED AND THEIR RESULTS.		
HAVE YOU EVER HAD ANY EMOTIONAL / MENTAL DISORDERS? ☐ YES ☐ NO / IF YES, WHEN? DESCRIBE BRIEFLY.		

SECTION 3 — LIFESTYLE		
DO YOU TAKE ☐ VITAMINS ☐ MINERALS ☐ HERBS		
DO YOU HAVE ANY DRUG ALLERGIES? ☐ YES ☐ NO / IF YES, WHAT?		
DO YOU DRINK ALCOHOL? ☐ HEAVY ☐ MODERATE ☐ LIGHT	DO YOU EXERCISE? HOW MANY HOURS PER WEEK?	DO YOU TAKE ANY NON-PRESCRIPTION OR RECREATIONAL DRUGS? ☐YES ☐NO
DO YOU SMOKE? ☐ YES ☐ NO HOW MANY CIGARETTES PER DAY?	HOW MANY HOURS PER NIGHT DO YOU SLEEP? ☐ SOUND ☐ LIGHT ☐ WAKE OFTEN ☐ UNREFRESHING	
ANYTHING ELSE WE SHOULD KNOW?		

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HEALTH QUESTIONS

Have you ever suffered from any of the following? Tick the left box for symptoms and conditions you have experienced in the past and the right box for symptoms and conditions you are experiencing now

GENERAL	PAST	NOW		PAST	NOW		PAST	NOW
CHILLS			CONVULSION			DIZZINESS		
FAINTING			FATIGUE			FEVER		
POOR SLEEP			WEIGHT LOSS			DEPRESSION		
ANXIETY			SWEATS			TREMORS		
HEAD/NECK	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
THYROID			GOITRE			ENLARGED GLANDS		
EYE PAIN			NOSE BLEEDS			EYESIGHT		
EAR NOISES			SKIN PROBLEMS					
STRUCTURAL	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
ARTHRITIS			BURSITIS			FOOT TROUBLE		
LOW BACK PAIN			CHEST PAIN			NECK PAIN		
UPPER BACK PAIN			HEADACHES			SCIATICA		
SWOLLEN JOINTS			POOR POSTURE			HERNIA		
PAIN OR NUMBNESS IN:								
ELBOWS			HANDS			HIPS		
LEGS			KNEES			FEET		
RESPIRATORY	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
ASTHMA			COLDS			EARACHE		
NASAL PROBLEMS			SINUS			TONSILS / THROAT		
COUGH			WHEEZE			LUNG PROBLEMS		
BREATHING DIFFICULTIES								
GASTRO-INTESTINAL	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
GAS / WIND			BLOATING			COLITIS		
CONSTIPATION			DIARRHEA			DIFFICULT DIGESTION		
HUNGER			GALL-BLADDER			HEMORRHOIDS		
JAUNDICE			LIVER			NAUSEA		
STOMACH PAIN			VOMITING			INDIGESTION		
CARDIO-VASCULAR	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
HIGH BLOOD PRESSURE			LOW BLOOD PRESSURE			CHEST PAIN		
RAPID HEART BEAT			VARICOSE VEINS			SWOLLEN ANKLES		
HARDENING OF ARTERIES			BRUISE EASILY			POOR CIRCULATION		
GENITO-URINARY	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
BED WETTING			INFECTIONS			KIDNEY/BLADDER STONES		
FREQUENT URINATION			INCONTINENCE			PAINFUL URINATION		
PROSTATE TROUBLE			PUS IN URINE					
WOMEN ONLY	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
CRAMPS / BACKACHE			EXCESSIVE FLOW			HOT FLUSHES		
IRREGULAR CYCLE			LUMPS IN BREAST			MENOPAUSE		
MENSTRUAL PAIN			THRUSH			PRE-MENSTRUAL TENSION		
SKIN	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
ACNE			ECZEMA			DERMATITIS		
PSORIASIS			HIVES			ALLERGIC RASHES		
COLD SORES			MOUTH ULCERS			OTHER		
ALLERGIES	**PAST**	**NOW**		**PAST**	**NOW**		**PAST**	**NOW**
HIVES			SINUSITIS			FOODS		
ASTHMA			HAY-FEVER			OTHER		
SKIN			ITCHINESS			IRITIS		
ATHLETES FOOT								
ALLERGIES TO:			ANIMALS			FLOWERS		
POLLEN			DUST					

TICK ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ MS	☐ ARTHRITIS	☐ CANCER	☐ DIABETES	☐ DIPHTHERIA	☐ RHEUMATIC FEVER	☐ EPILEPSY	☐ TUBERCULOSIS
☐ GOUT	☐ ULCERS	☐ MALARIA	☐ MEASLES	☐ MISCARRIAGE	☐ SCARLET FEVER	☐ PLEURISY	☐ PNEUMONIA
☐ POLIO	☐ ANAEMIA	☐ STROKE	☐ GOITRE	☐ HEART DISEASE	☐ CHICKEN POX	☐ MUMPS	☐ EMPHYSEMA

Authorisation for Care - I give my informed consent and authorise the practitioners of Integrated Health Care to administer the Hale Technique, Homeopathy, Nutrition and Chiropractic Care. I clearly understand and agree that I am personally responsible for payment of all fees charged by Integrated Health Care on the day of service. I acknowledge that I have access to my information as per the Privacy Act and that all information supplied is private and confidential.

NAME_____ DATE / / SIGNED_____

Integrated Health Care produces a quarterly newsletter. Tick if you would like to receive a copy by email ☐