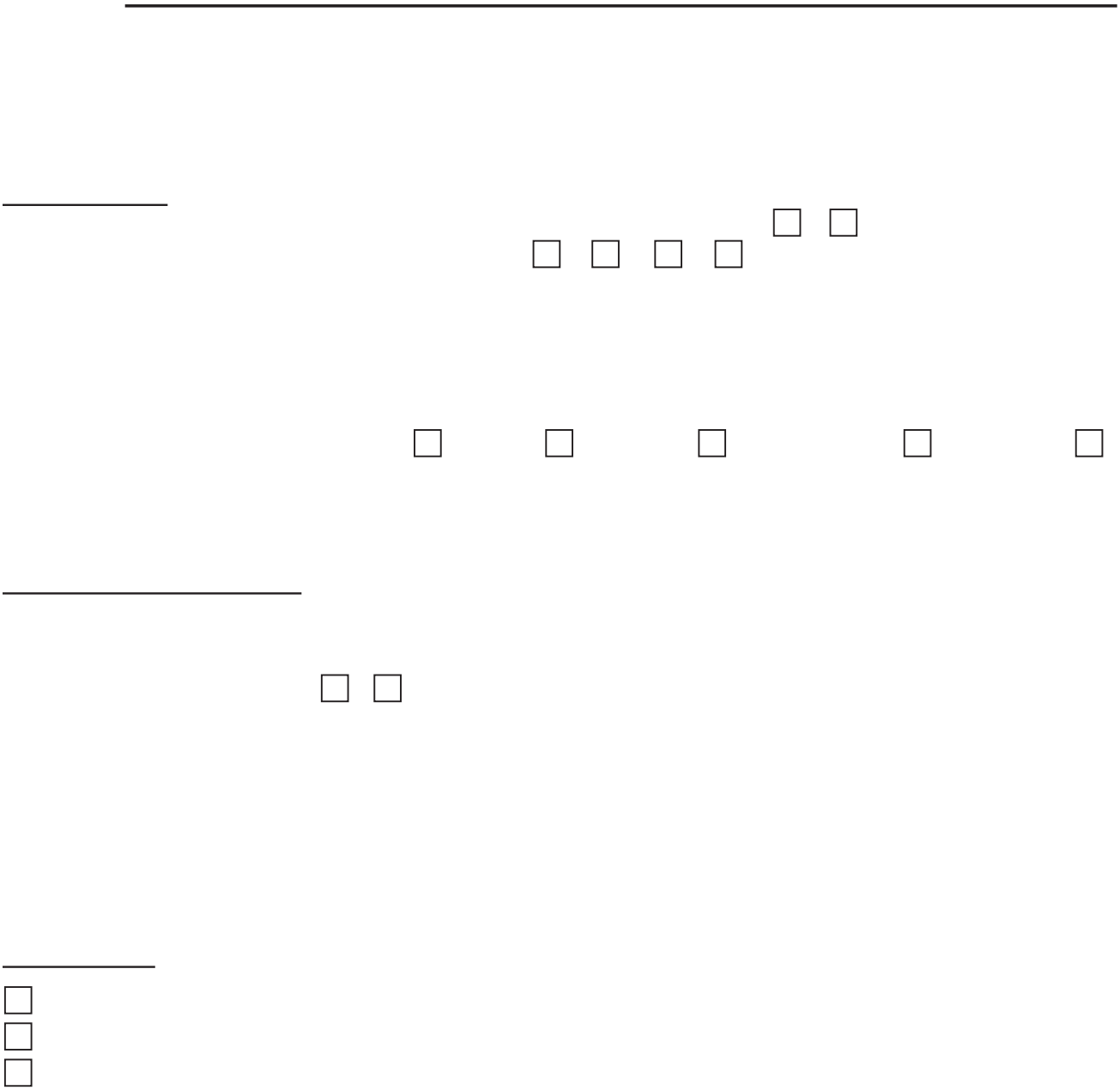

CASE HISTORY:

HEALTH CONCERNS: Please list your Top Health Concerns in order of priority, When they started and Grade them on a scale of 1 to 10 (1 = virtually not a problem….10 = thoughts of suicide it's so bad).

	Date of Onset	Grade
1)_____	_____	1 2 3 4 5 6 7 8 9 10
2)_____	_____	1 2 3 4 5 6 7 8 9 10
3)_____	_____	1 2 3 4 5 6 7 8 9 10

Is the condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other_____

How long has it been since you felt really good? ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ > 10 Years

PLEASE CHECK ONE BOX FOR EACH OF THE SYMPTOMS THAT APPLY, USING THIS KEY:

N = Never R = Rarely F = Frequently A = Always

N	R	F	A		N	R	F	A		N	R	F	A	
☐	☐	☐	☐	Headache	☐	☐	☐	☐	Rapid Heart Rate	☐	☐	☐	☐	Swollen Ankles
☐	☐	☐	☐	Facial Pain	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	Ankle/ Foot Pain
☐	☐	☐	☐	Eye Pain	☐	☐	☐	☐	Low Blood Pressure	☐	☐	☐	☐	Tingling of Feet
☐	☐	☐	☐	Blurred Vision	☐	☐	☐	☐	Stomach Pains	☐	☐	☐	☐	Walking Problems
☐	☐	☐	☐	Di z z iness	☐	☐	☐	☐	Nausea/Vomiting	☐	☐	☐	☐	Sore Muscles
☐	☐	☐	☐	Earache	☐	☐	☐	☐	Poor Appetite	☐	☐	☐	☐	Weak Muscles
☐	☐	☐	☐	Forgetfulness	☐	☐	☐	☐	Fullness of Bladder	☐	☐	☐	☐	Paralysis
☐	☐	☐	☐	Confusion	☐	☐	☐	☐	Urinary Difficulty	☐	☐	☐	☐	Shakiness
☐	☐	☐	☐	Sinusitis	☐	☐	☐	☐	Frequent Urination	☐	☐	☐	☐	Sweating
☐	☐	☐	☐	Teeth Grinding	☐	☐	☐	☐	Constipation	☐	☐	☐	☐	Insomnia
☐	☐	☐	☐	Dry Mouth	☐	☐	☐	☐	Hemorrhoids	☐	☐	☐	☐	Fainting
☐	☐	☐	☐	E x cessive Thirst	☐	☐	☐	☐	Decreased Se x Drive	☐	☐	☐	☐	Convulsions
☐	☐	☐	☐	Unpleasant Taste	☐	☐	☐	☐	Menstrual Irregularities	☐	☐	☐	☐	Irritability/Impatience
☐	☐	☐	☐	Neck Pain	☐	☐	☐	☐	Elbow/ Hand Pain	☐	☐	☐	☐	Fatigue/Loss on Energy
☐	☐	☐	☐	Sore Throat	☐	☐	☐	☐	Tingling in Hands	☐	☐	☐	☐	Feel Loss of Control
☐	☐	☐	☐	Lump in Throat	☐	☐	☐	☐	Clammy Hands	☐	☐	☐	☐	Crave Salts
☐	☐	☐	☐	Swallowing Pain	☐	☐	☐	☐	Low Back Pain	☐	☐	☐	☐	Crave Sweets
☐	☐	☐	☐	Unsteady Voice	☐	☐	☐	☐	Hip Pain	☐	☐	☐	☐	Symptoms?
☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐	?
☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐	
☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐	
☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐	

ALLERGIES: Please list any Allergies you may have, including medications, foods, seasonal, environmental, etc.
☐ None ☐ The following:_____

MEDICATIONS: Please list all medications that you are currently taking with the date you began taking them in parenthesis. i.e. Coumadin(May 1998), Celebre x (J an 2007) ☐ None ☐ The Following:_____

_____

SCARS / SURGICAL PROCEDURES: List all scars and surgeries: ☐ None ☐ The Following:_____

_____

SUPPLEMENTS: Do you take Vitamins/Supplements/Herbs/Homeopathics? ☐Y ☐N, If Yes, What are you taking and Who recommended them? _____

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda Pop	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐
Junk Food	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐
Dieting	☐	☐	☐	☐
Relaxation	☐	☐	☐	☐

	5-7 x/wk	3-5 x/wk	1-3 x/wk	Type	Time
Exercise	☐	☐	☐	_____	_____

	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	< 5 hrs	Quality?
Sleep	☐	☐	☐	☐	☐	☐Y ☐N

	5+/day	4/day	3/day	2/day	1/day
Meals	☐	☐	☐	☐	☐

	64+ oz	32-64 oz	16-32 oz	< 8 oz
Water	☐	☐	☐	☐

	2+ Hrs	1-2 Hrs	30-60 Min	10-30 Min	< 10 Min
Cell ph. Use	☐	☐	☐	☐	☐

	4+/day	3/day	2/day	1/day	< 1/day
Bowels	☐	☐	☐	☐	☐

Females: Date of last menstrual period _____ Pregnant ☐Y ☐N ☐Maybe Nursing ☐Y ☐N

FAMILY HISTORY: Check any Conditions that you, or any of your family members have now or have had in the past, that you know of: (G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self. Mark all that apply)

G	M	F	S	X	
☐	☐	☐	☐	☐	Alcoholism
☐	☐	☐	☐	☐	Anemia
☐	☐	☐	☐	☐	Cancer
☐	☐	☐	☐	☐	Deep Vein Thrombosis
☐	☐	☐	☐	☐	Heart Disease
☐	☐	☐	☐	☐	Diabetes
☐	☐	☐	☐	☐	Diverticulitis/IBS
☐	☐	☐	☐	☐	Eczema
☐	☐	☐	☐	☐	Emphysema
☐	☐	☐	☐	☐	Epilepsy
☐	☐	☐	☐	☐	Goiter
☐	☐	☐	☐	☐	Gout
☐	☐	☐	☐	☐	Hepatitis

G	M	F	S	X	
☐	☐	☐	☐	☐	HIV/AIDS
☐	☐	☐	☐	☐	Miscarriage
☐	☐	☐	☐	☐	Pleurisy
☐	☐	☐	☐	☐	Pneumonia
☐	☐	☐	☐	☐	Rheumatic Fever
☐	☐	☐	☐	☐	Polio
☐	☐	☐	☐	☐	Seizures/Fainting
☐	☐	☐	☐	☐	Stroke
☐	☐	☐	☐	☐	Tumor(s)
☐	☐	☐	☐	☐	Ulcers
☐	☐	☐	☐	☐	Vaccine Reaction
☐	☐	☐	☐	☐	Other: _____

_____

PRIVACY NOTICE:

Patient Health Information:

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

1. The patient understands and agrees to allow Mousselli Chiropractic Corporation of Oxnard to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care
2. The patient has the right to examine and obtain a copy of his/her health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without written permission.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.