## **Patient Medical Case History**

Name:	Date:			
Please describe the history of your current problem over the past 6 months:  What activities could you do before this problem that you cannot do now:  What treatment have you had for this problem?  Please check if you have a history of any of the following:  MEUROLOGICAL Stroke/TIA Brain Injury Seizures/Epilepsy Numbness/Tingling Parkinson's Dizziness/Vertigo Severe Headaches Coordination or balance problems other:  ONCOLOGY! METABOLIC Cancer Thyroid Disease Diabetes Blood Clotting Loss (circle) Impaired Speech/ Swallowing Disorder Nausear/Vomiting Immune Deficiency other:  ONY Other Psychiatric Disorder Claustrophobia Immune Deficiency other:  On you have any allergies? No_Yes	Name:	Home Phone:	Work:	
What activities could you do before this problem that you cannot do now:  What treatment have you had for this problem?  Please check if you have a history of any of the following:    MEUROLOGICAL   Stroke/TIA   Brain Injury   Seizures/Epilepsy   Numbness/Tingling   Parkinson's   Dislocations   Neck Pain/Injury   Back Pain/Injury   Arthritis   Osteoprosis   Joint Replacement   Valent   Merce   Osteoprosis   Joint Replacement   Pacemaker/ Heart Beat   Short of Breath   Asthma   Pacemaker/ Heart Device   Other:    ONCOLOGY/	Emergency Contact:	Relationship:	Phone:	
What treatment have you had for this problem?  Please check if you have a history of any of the following:    NEUROLOGICAL   Stroke/TIA   Brain Injury   Seizures/Epilepsy   Numbness/Tingling   Parkinson's   Dislocations   Neck Pain/Injury   Back Pain/Injury   Arthritis   Osteoporosis   Joint Replacement   Asthma   Pacemaker/ Heart Device   Other:   OTHER CONDITIONS   Chlorine Sensitivity   Open Wound/Rash   Bladder/Bowel   Chlorine Sensitivity   Open Wound/Rash   Bladder/Bowel   Control Problems   Ear Drum Injury   Other:   Current Medications:   See List   Do you have any allergies? No Yes   Patient Signature:	Please describe the history	of your current problem over the past	6 months:	
NEUROLOGICAL   Stroke/TIA   Brain Injury   Bilood pressure   High or Low (circle)   Heart Attack   Chest Pain   Irregular Heart Beat   Short of Breath   Asthma   Pacemaker/ Heart Device   Other:   Other Swallowing   Disorder   Nausea/Vomiting   Immune Deficiency   Immune Deficiency   Other   Suzures   Doyou have any allergies? NoYes (please list)   Patient Signature:				
Stroke/TIA   Brain Injury   Seizures/Epilepsy   Numbness/Tingling   Parkinson's   Dizziness/Vertigo   Severe Headaches   Coordination or balance problems other:   Diabetes   Diabetes   Diabetes   Diabetes   Blood Clotting   Disorder   Neck Pain/Injury   Blood pressure   High or Low (circle)   Heart Attack   Chest Pain   Irregular Heart Beat   Short of Breath   Asthma   Pacemaker/   Heart Device   Other:   Doyou have any allergies? No Yes   Patient Signature:   Patient Signature:	What treatment have you h	ad for this problem?		
Stroke/TIA Brain Injury Seizures/Epilepsy Numbness/Tingling Parkinson's Dizziness/Vertigo Severe Headaches Coordination or balance problems other:    ONCOLOGY/ METABOLIC Cancer Thyroid Disease Diabetes Blood Clotting Disorder Nausear/Vomiting Immune Deficiency other:   Immune Deficiency other:   Current Medications:   See List	Please check if you have a	history of any of the following:	<u> </u>	
METABOLIC       Vision/Hearing       PATIENTS         Cancer       Loss (circle)       Fear of Water         Thyroid Disease       Impaired Speech/       Chlorine Sensitivity         Diabetes       Swallowing       Open Wound/Rash         Blood Clotting       Depression/Anxiety       Sladder/Bowel         Control Problems       Ear Drum Injury         Claustrophobia       Ear Drum Injury         Memory Loss       other:         Other:       Do you have any allergies? No Yes         (please list)       Next appointment with referring doctor:         Is this case under litigation? No Yes	Stroke/TIA Brain Injury Seizures/Epilepsy Numbness/Tingling Parkinson's Dizziness/Vertigo Severe Headaches Coordination or balance problems	Fractures Dislocations Neck Pain/Injury Back Pain/Injury Arthritis Osteoporosis Joint Replacement where:	Blood pressure High or Low (circle) Heart Attack Chest Pain Irregular Heart Beat Short of Breath Asthma Pacemaker/ Heart Device	
(please list)  Next appointment with referring doctor:  Is this case under litigation? No Yes  Patient Signature:	METABOLIC  Cancer Thyroid Disease Diabetes Blood Clotting Disorder Nausea/Vomiting Immune Deficiency	Vision/Hearing Loss (circle)Impaired Speech/ SwallowingDepression/AnxietyOther Psychiatric DisorderClaustrophobiaMemory Loss	PATIENTS  Fear of Water Chlorine Sensitivity Open Wound/Rash Bladder/Bowel Control Problems Ear Drum Injury other:	
Mext appointment with referring doctor:  [May use back of page] Is this case under litigation? No Yes  Patient Signature:	Current Medications:   See			
Date: (label)	Patient Signature:			
	Date:		(label)	