Confidential Patient Care History

Please fill out completely and print clearly. Thank you. This information is kept confidential in accordance with HIPPA Regulations.

Name: ________________________________ Home Phone: ____________________ Cell Phone: ____________________________

Address: ____ Work Phone: ____________________________

City: ___________________________ State: _______ Zip Code: ___________ E-Mail: __________________________________

Date of Birth: _________________Age: ________Sex: _______Marital Status: __________________
# of Children: _______________

Employer Name and Address: ____ Occupation: ________________________

Spouse's Name: __________________________________ Employer: ____

Referred By: Yellow Pages: _______ Print Advertisement: _______ Other Dr.: _______ Radio Ad: _______
Patient: _______ Referral Name: _____________________ Radio Program w/Dr. Heise: ______
Other: ____

What is/are your major complaint(s)?: ____

____

How long have you had this/these condition(s)?:
____

OPERATIONS

Date: _____________ Tonsillectomy Date: _____________ Appendectomy Date: _____________ Hernia
Date: _____________ Gall Bladder Date: _____________ Female Organs Date: _____________ Thyroid
Date: _____________ Back Operations Date:_____________ Rectal Surgery
Other: (List type of surgery and date)____

ACCIDENTS OR FALLS (Childhood and Adult): ____

____

BROKEN BONES OR DISLOCATIONS: ____

____

Were you ever knocked unconscious?: Yes: _____ No: _____
Have you ever had memory lapse?: Yes: _____ No: _____

Are you presently taking any medications? Prescription or Patent? ______ If so, what drugs?: ______________________________

____

Are you presently taking any vitamins or minerals substances?: ______ If so, which ones?: ______________________________

____

List any treatment contraindications, allergy, adverse reactions: ____

____

If you have one or more of these symptoms, there's a 95% probability you'll benefit from a food sensitivity test.

Please place a checkmark at each of your symptoms and be sure to include symptoms that you've "learned to live with".

Digestive Tract
- ▫ Belching
- ▫ Bloated Feeling
- ▫ Constipation
- ▫ Diarrhea
- ▫ Nausea
- ▫ Passing gas
- ▫ Stomach pains
- ▫ Vomiting

Ears
- ▫ Drainage from ear
- ▫ Ear aches
- ▫ Ear infections
- ▫ Hearing loss
- ▫ Itchy ears
- ▫ Ringing in ears

Emotions
- ▫ Aggressiveness
- ▫ Anxiety/fear
- ▫ Depression
- ▫ Irritability/anger
- ▫ Mood Swings
- ▫ Nervousness

Energy & Activity
- ▫ Apathy
- ▫ Fatigue
- ▫ Hyperactivity
- ▫ Lethargy
- ▫ Restlessness
- ▫ Sluggishness

Eyes
- ▫ Blurred Vision
- ▫ Dark Circles
- ▫ Itchy eyes
- ▫ Sticky eyelids
- ▫ Swollen eyelids
- ▫ Watery eyes

Head
- ▫ Dizziness
- ▫ Faintness
- ▫ Headaches
- ▫ Insomnia
- ▫ Lightheadedness

Joint & Muscles
- ▫ Aches in muscles
- ▫ Arthritis
- ▫ Feeling of weakness
- ▫ Limited movement
- ▫ Pain in joints
- ▫ Stiffness

Lungs
- ▫ Asthma/bronchitis
- ▫ Chest congestion
- ▫ Difficulty breathing
- ▫ Shortness of breath
- ▫ Wheezing

Mind
- ▫ Confusion
- ▫ Learning disabilities
- ▫ Poor concentration
- ▫ Poor memory
- ▫ Stuttering/stammering

Mouth & Throat
- ▫ Canker sores
- ▫ Chronic coughing
- ▫ Gagging
- ▫ Often clear throat
- ▫ Sore throat
- ▫ Swollen tongue/lips/gums

Nose
- ▫ Excessive mucous
- ▫ Hay fever
- ▫ Sinus problems
- ▫ Sneezing attacks
- ▫ Stuffy nose

Skin
- ▫ Acne
- ▫ Dermatitis
- ▫ Eczema
- ▫ Excessive sweating
- ▫ Flushing/hot flashes
- ▫ Hair loss
- ▫ Hives/rashes
- ▫ Itching

Weight
- ▫ Binge eating
- ▫ Compulsive eating
- ▫ Cravings
- ▫ Excessive weight
- ▫ Underweight
- ▫ Water retention

Other
- ▫ Anaphylactic reactions
- ▫ Chest pains
- ▫ Frequent illness
- ▫ Genital itch
- ▫ Irregular heartbeat
- ▫ Rapid Heartbeat
- ▫ Urgent urination

PAYMENT IS EXPECTED AT TIME OF VISIT.

____________________ DATE

______________________________________ PATIENT OR GUARDIAN (IF MINOR)