PERIPHERAL NEUROPATHY CASE HISTORY

Whatever label has been given to you, keep in mind that is just a label. It doesn't tell us what to do. Your answers to these questions and the results of your examination will tell me how to help you as fast as possible. I look forward to working with you.

Sincerely,

Dr. Christopher Heimlich, D. C.

Name ________________________________Date of birth ___________Date ________

Address_________________________________City________________Zip__________

Home phone _____________Cell Phone _______________Work phone _____________

E-mail____

In case of emergency, notify: ____

Has there been any diagnosis of your symptoms/conditions? ☐ Yes ☐ No

If yes, please list the diagnosis, who made the diagnosis and the date diagnosis was made:

____
____
____

History of concussion? ______What side of your head? ______ History of stroke?______

What side of your brain? ______ Do you have difficulty in understanding what others say

to you? _____ Do you have difficulty being comfortable in social situations? ______

Hobbies: Art__________ Music _________ Sports__________ Games____________

Are you ☐ right handed ☐ left handed ☐ switches with different activities
☐ was left handed, but now is right ☐ was right handed, but now is left

Please use this space to describe your history. Please tell us about:

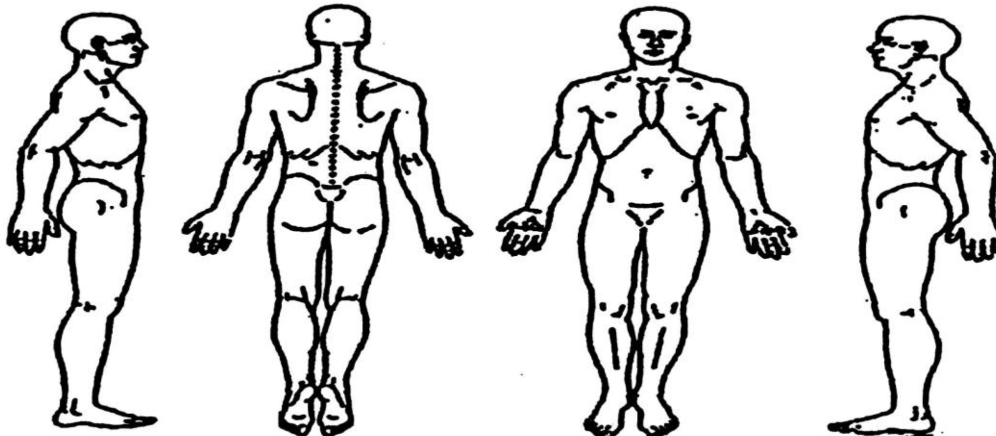
- The main problems/concerns or symptoms that you are experiencing. List them.
- When did these problems start? How have they changed over time?
- What have you tried to help this? (Medications, therapies, diet, supplements, etc.)
- What was the response? (helped, worse, no change)
- What do you think makes these symptoms worse?
- What do you think makes these symptoms better?
- TELL ME AS MUCH AS YOU CAN! Use extra paper if necessary.

PATIENT INTAKE FORM

Patient Name: _____________________________ Date: _______________

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:___________________

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? ___________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height___________ Weight _____________ Date of Birth ___________
Occupation ____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ Autoimmune Condition

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Thyroid Condition	□	□ Dizziness		
□	□ Other:____________________________				

20. List all prescription medications you are currently taking:
____

21. List all of the over-the-counter medications you are currently taking:
____

22. List all surgical procedures you have had:
____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?____

Patient Signature___________________________________ **Date:**____________________

Please mark the following in each category by ranking each one 0-4.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

Trouble sustaining attention in routine situations ______
Difficulty remembering where things are ______
Trouble recognizing the emotion in someone's voice ______
Bad memory for directions ______
Don't respond well to new situations ______
Difficulty understanding body language ______
Don't understand the 'big picture' of words / phrases ______
Often don't get humor and metaphors Not Able to "read between the lines"______
Act compulsively inappropriate social behavior and responses ______
Difficulty with word problems ______
Not Able to focus ______
Difficulty following through or finishing things ______
Not Able to 'tune out' irrelevant stimuli ______
Trouble imagining or visualizing an activity or physical action ______
Not Able to speak without sounding monotone ______
Trouble with reading comprehension ______
Blurting out of answers before question is completed ______
Hyperactive-move excessively ______
Trouble understanding symbolism in words and art ______
Not Able to control what you say ______
Not Able to cry or be spontaneous ______
Not Able to predict what others will do Irregular heart rate (fast or slow) ______
Feel fearful and anxious ______
Easily distracted by ordinary insignificant things ______

Not Able to remember facts and figures ______
Trouble understanding when spoken to ______
Not Able to speak clearly ______
Not Able to identify objects by name ______
Can't find words when talking ______
Trouble with fine motor skills (small objects, handwriting, buttons) ______
Not Able to draw pictures accurately ______
Not able to focus on smaller details ______
Difficulty with calculations/math ______
Depression (even if in the past) ______
Trouble reading (dyslexic)-even if past only ______
Trouble following multiple step directions ______
Upset if routine or plan changes ______
Irregular heart rhythm (skipped beats, fluttering) ______
Have repetitive thoughts ______
Excessively motivated ______
Can't turn thoughts off at night ______
Tend to write very small ______
Start things, but don't finish ______

Very good at finding mistakes ______

SCOTTSDALE CHIROPRACTIC
AND NUTRITION CENTER
6501 E. GREENWAY PKWY. SUITE #157
SCOTTSDALE, AZ 85254
480-991-9355

Name ____ Date ____________________

Please take several minutes to answer these questions so Dr. Heimlich can help you get better faster. Please circle as many that apply.

1. How have you taken care of your health in the past?

a. Medications
b. Emergency room
c. Routine medical
d. Exercise
e. Nutrition/Diet
f. Holistic care
g. Vitamins
h. Chiropractic
i. Other (please specify) ____

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples.

____

____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc) Give three examples.

____

____

What are you most concerned with regarding your problem?

____

____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

____

____

What would be different/better without this problem? Please be specific.

____

____

What do you desire most to get from working with us?

____

____

What is that worth to you?

____

____

Metabolic Assessment Form

Name: ____ **Age:** _____ **Sex:** ____ **Date:** ____________

PART I

Please list the 5 major health concern in your order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____

PART II **Please check mark the appropriate number "0 - 3" on all questions below.**
0 as the least/never to 3 as the most/always.

Category I	0	1	2	3
Feeling that bowels do not empty completely				
Lower abdominal pain relief by passing stool or gas				
Alternating constipation and diarrhea				
Diarrhea				
Constipation				
Hard dry or small stool				
Coated tongue of "fuzzy" debris on tongue				
Pass large amount of foul smelling gas				
More than 3 bowel movements daily				
Do you use laxatives frequently				

Category II	0	1	2	3
Excessive belching burping or bloating				
Gas immediately following a meal				
Offensive breath				
Difficult bowel movements				
Sense of fullness during and after meals				
Difficulty digesting fruits and vegetables; undigested foods found in stools				

Category II	0	1	2	3
Stomach pain, burning or aching 1- 4 hours after eating				
Do you frequently use antacids				
Feeling hungry an hour or two after eating				
Heartburn when lying down or bending forward				
Temporary relief from antacids, food, milk, carbonated beverages				
Digestive problems subside with rest and relaxation				
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine				

Category IV	0	1	2	3
Roughage and fiber cause constipation				
Indigestion and fullness lasts 2-4 hours after eating				
Pain, tenderness, soreness on left side				
Under rib cage bloated				
Excessive passage of gas				
Nausea and/or vomiting				
Stool undigested, foul smelling, Mucous-like, greasy or poorly formed				
Frequent urination				
Increased thirst and appetite				
Difficulty losing weight				

Category V	0	1	2	3
Greasy or high fat foods cause distress				
Lower bowel gas and or bloating several hours after eating				
Bitter metallic taste in mouth, especially in the morning				
Unexplained itchy skin				
Yellowish cast to eyes				
Stool color alternates for clay colored to normal brown				
Reddened skin, especially palms				
Dry or flaky skin and/or hair				
History of gallbladder attacks or stones				
Have you had your gallbladder removed	Yes		No	

Category VI	0	1	2	3
Crave sweets during the day				
Irritable if meals are missed				
Depend on coffee to keep yourself going or started				
Get lightheaded and if meals are missed				
Eating relieves fatigue				
Feel shaky, jittery, tremors				
Agitated, easily upset, nervous				
Poor memory, forgetful				
Blurred vision				

Category VII	0	1	2	3
Fatigue after meals				
Crave sweets during the day				
Eating sweets does not relieve cravings for sugar				
Must have sweets after meals				
Waist girth is equal or larger than hip girth				
Frequent urination				
Increased thirst & appetite				
Difficulty losing weight				

Category VIII	0	1	2	3
Cannot stay asleep				
Crave salt				
Slow starter in the morning				
Afternoon fatigue				
Dizziness when standing up quickly				
Afternoon headaches				
Headaches with exertion or stress				
Weak nails				

Copyright © Datis Kharrazian 2003; Functional Endocrinology Seminar – Apex Energetics

Category IX	0	1	2	3
Cannot fall asleep				
Perspire easily				
Under high amounts of stress				
Weight gain when under stress				
Wake up tired even after 6 or more hours of sleep				
Excessive perspiration or perspiration with little or no activity				

Category X	0	1	2	3
Tired, sluggish				
Feel cold – hands, feel, all over .				
Require excessive amounts of sleep to function properly				
Increase in weight gain even with low-calorie diet				
Gain weight easily				
Difficult, infrequent bowel movements				
Depression, lack of motivation				
Morning headaches that wear off as the day progresses				
Outer third of eyebrow thins				
Thinning of hair on scalp, face or genitals or excessive falling hair				
Dryness of skin and/or scalp				
Mental sluggishness				

Category XI	0	1	2	3
Heart palpations				
Inward trembling				
Increased pulse even at rest				
Nervousness and emotional				
Insomnia				
Night sweats				
Difficulty gaining weight				

Category XII	0	1	2	3
Diminished sex drive				
Menstrual disorders of lack of menstruation				
Increased ability to eat sugars without symptoms				

Category XIII	0	1	2	3
Increased sex drive				
Tolerance to sugars reduced				
“Splitting” type headaches				

Category XIV (Male Only)	0	1	2	3
Urination difficulty or dribbling				
Urination frequent				
Pain inside of legs or heels				
Feeling of incomplete bowel evacuation				
Leg nervousness at night				

Category XV (Males Only)	0	1	2	3
Decrease in libido				
Decrease in spontaneous morning erections				
Decrease in fullness of erections				
Difficulty in maintain morning erections				
Spells of mental fatigue				
Inability to concentrate				
Episodes of depression				
Muscle soreness				
Decrease in physical stamina				
Unexplained weight gain				
Increase in fat distribution around chest and hips				
Sweating attacks				
More emotional then in the past				

Category XVI (Menstruating Females Only)	0	1	2	3
Are you a menopausal	**Yes**		**No**	
Alternating menstrual cycle lengths	**Yes**		**No**	
Extended menstrual cycle, greater than 32 days	**Yes**		**No**	
Shortened menses, less than every 24 days	**Yes**		**No**	
Pain and cramping during periods				
Scanty blood flow				
Heavy blood flow				
Breast pain and swelling during menses				
Pelvic pain during menses				
Irritable and depressed during menses				
Acne break outs				
Facial hair growth				
Hair loss/thinning				

Category XVII (Menopausal Females only)	0	1	2	3
How many years have you been menopausal?	________			
Do you ever have uterine bleeding since menopause?	**Yes**		**No**	
Hot flashes				
Mental fogginess				
Disinterest in sex				
Mood swings				
Depression				
Painful intercourse				
Shrinking breast				
Facial hair growth				
Acne				
Increased vaginal, pain, dryness or itching				

PART III

How many alcohol beverages they consume per week? ___________

How many times do you eat out per week? ___________

How many times a week do you eat fish? ___________

How many caffeinated beverages do you consume per day? __________

How many times a week do you eat raw nuts or seeds? _____________

How many times a week do you workout? ____________

List the three worst foods you eat during the average week? _____________________, ______________________, _____________________

List the three healthiest foods you eat during the average week? _____________________, ______________________, ____________________

Do you smoke?_______ If yes, how many times a day ____________ , a week ____________.

Rate your stress levels on a scale of 1-10 during the average week. __________________

Please list any medications you currently take and for what conditions:

____

Please list any natural supplements you currently take and for what conditions:

____

***Write down **EVERYTHING** you eat & drink for 3 days. What you're eating and when you're eating can have a **HUGE NEGATIVE EFFECT** on your health.**

Day 1

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

Day 2

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

Day 3

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

****IMPORTANT****

PLEASE READ THIS PAGE CAREFULLY

In order for you to get better as fast as possible, we need the help of ALL persons significantly involved in your support system. Spouses, friends and family members all play a crucial role in your treatment and the results that you achieve. In short, it is extremely important that all of your support system are “on the same page.”

Therefore, we require that all persons directly involved with your support system watch the video sent to you and then sign this affidavit. This form must be returned with your Case History forms before Dr. Heimlich can examine you.

AFFIDAVIT

I (each) the undersigned individual certify that:

- I have viewed the video from Dr. Heimlich titled *Peripheral Neuropathy*
- I understand that Dr. Heimlich methods and treatment are unique.
- I understand that Dr. Heimlich does not accept every person into his treatment program.

Print Name	Signature
______________________________	______________________________
Print Name	Signature
______________________________	______________________________
Print Name	Signature
______________________________	______________________________
Print Name	Signature
______________________________	______________________________
Print Name	Signature

Thank you for taking the time to make sure you get the best results possible in the fastest time.

Return this paper with your Case History forms.