

# CONFIDENTIAL PATIENT CASE HISTORY

Dear patient: Please complete this health questionnaire. Your answers will help us determine in what ways we can help you. We will only accept your case if we believe your conditions will respond satisfactorily. Rest assured that all information will remain completely confidential. Thank you

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Birth Date \_\_\_\_\_ M/F Marital Status \_\_\_\_\_ # of Children \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_ Referred By \_\_\_\_\_

Read through the following list of symptoms for the health conditions that apply to you. **P** for past, **O** for Occasional, **F** for Frequent and **C** for Constant

### GENERAL

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Sweating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors

### MUSCLE & JOINT

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower back pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbago
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or stiffness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or Numbness in:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knees
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tail bone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints

### RESPIRATORY

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting of blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting of phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing

### GASTRO-INTESTINAL

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or Gas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal distension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal parasites
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood

### EYES, EARS, NOSE & THROAT

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental decay
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear aches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Far-sightedness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Obstruction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near-sightedness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis

### CARDIOVASCULAR

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles

### SKIN

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions (rash)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins

### GENITO-URINARY

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control kidneys
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infections/stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pus in urine

### GYNECOLOGICAL (FEMALES ONLY)

P	O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast congestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or backaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive menstrual flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breasts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal symptoms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge

### SEXUALITY (OPTIONAL)

<input type="checkbox"/>	Abstainer
<input type="checkbox"/>	Bisexual
<input type="checkbox"/>	Heterosexual
<input type="checkbox"/>	Homosexual

How long has it been since you've felt really good? \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Medications: \_\_\_\_\_

Age of mattress \_\_\_\_\_

Do you wear:  Heel lifts

Comfortable

Uncomfortable

Bed Supports

Sole lifts

Inner Soles

Arch Supports

Have you ever had any mental or emotional disorders? \_\_\_\_\_

Have others in the family had such disorders? \_\_\_\_\_

**FAMILY HEALTH INFORMATION**

RELATION

PAST/PRESENT HEALTH PROBLEMS

**HAVE YOU EVER:**

Yes No

Describe

Been knocked unconscious?

Used a crutch, cane or other support?

Been treated for a spine/nerve disorder?

Had a fractured bone?

Been hospitalized for other than surgery?

**DO YOU**

Now take supplements?

Think you may need supplements?

Have an allergy to any medication?

Please list all allergies. \_\_\_\_\_

**DATE OF LAST**

Less than 6 mo.

6 -18 mo.

Over 18 mo.

Never

Spinal examination

Physical examination

Blood test

Chest x-ray

Spinal x-ray

Dental x-ray

Urine test

**HABITS**

Heavy

Moderate

Light

Alcohol

Coffee

Tobacco

Drugs

Exercise

Sleep

Appetite

**PLEASE CHECK FOLLOWING CONDITIONS YOU HAVE HAD:**

- Anemia
- Appendicitis
- Arteriosclerosis
- Arthritis
- Cancer
- Chorea
- Cold Sores
- Diabetes
- Diphtheria
- Eczema
- Emphysema
- Epilepsy
- Fever Blister
- Goiter
- Gout
- Heart Disease
- Influenza
- Lumbago
- Malaria
- Measles
- Miscarriage
- Multiple Sclerosis
- Mumps
- Pleurisy
- Pneumonia
- Polio
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Substance Abuse
- Tuberculosis
- Typhoid Fever
- Ulcers
- Venereal Disease
- Whooping Cough

What is your major complaint? \_\_\_\_\_  
Other complaints? \_\_\_\_\_  
How long have you had this condition? \_\_\_\_\_ Have you had this or similar condition in the past? \_\_\_\_\_  
What activities aggravate your condition? \_\_\_\_\_  
Is this condition worsening?  Yes  No  Constant  Comes and goes  
Is this condition interfering with:  Work  Sleep  Daily Routine  Others

List all conditions for which you have been treated in the past 10 years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Blood Type and Health Study Informed Consent Form

1. I have been invited to participate in a study conducted by the D'Adamo Institute
2. I have been informed that the purpose of the research is to determine the relationship between blood type and health
3. My participation will involve the completion of this intake form and the typing of my blood.
4. I understand that I may withdraw from the study at any time for any reason without penalty or prejudice toward me.
5. I understand that side effects from blood typing include brief pain and minor bleeding. The finger prick technique will be done under standard and sterile conditions by a doctor. Bruising of the skin or a feeling of faintness is possible.
6. I understand that the possible benefits of my participation in the research are in a general way to provide information helpful in the understanding of how blood type interacts with health.
7. I understand that the results of the research study may be published, but that my name or identity will not be revealed.
8. I understand that in case of injury from the finger stick I can expect to receive care at the Institute.
9. I have been informed that I will be given the results of my blood typing.
10. I have been informed that any questions I have concerning the research study or my participation in it, before or after my consent, will be answered by one of the doctors.
11. I have read the above informed consent. The nature, demands, benefits and any risk of the project have been explained to me. I knowingly assume any risks involved. I understand that I may withdraw my consent and discontinue participation at any time without penalty or loss of benefit to myself.

Date: \_\_\_\_\_ Subject's Signature: \_\_\_\_\_

12. "I certify that I have explained to the above individual the nature and purpose, the potential benefits and possible risks associated with participation in this research study, have answered any questions that have been raised, and have witnessed the above signature."
13. "I have provided the subject a copy of this signed consent document if desired."

Date: \_\_\_\_\_ Signature of Investigator: \_\_\_\_\_

In Case Of Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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