Upledger Institute Clinic Group Therapy Program

Confidential Case History for the Upledger Intensive Program

Please complete and return by mail or fax or e mail to:
The Upledger Institute Clinic 11211 Prosperity Farms Rd., Suite D-223 Palm Beach Gardens, FL 33410
Phone: 561.622.4706 Fax: 561.627.9231 E-mail: clinic@iahe.com

Today's Date: _____

Program Attending: (Please check)

_____ February 16 – 20, 2018 _____ April 17 – 21, 2018 _____ September 5 -9, 2018

Name: _____ Date of Birth: ____/____/____ Age: ____ Male/Female

Address:
_____City_____State_____Zip_____

E-mail Address: _____ Cell Phone Number: (_____)
_____

Please circle if you would like to receive Upledger Information by email: Y / N

Emergency Contact Name:_____ Phone#: _____

If Referred, by Whom: _____

Diagnosis/Condition: _____

1. Briefly describe your present injury, diagnosis, condition, or symptoms that you are seeking help for.

Primary concern/Major complaint _____

_____

Other concerns/complaints _____

_____

2. Was the onset: ___Sudden ___ Gradual ___ Related to accident or trauma

3. When did you first notice major complaints: _____

_____

_____

4. Mark an "**A**" for activities that **A**ggravate or worsen your symptoms. Mark an "**R**" for those that help to **R**elieve or make them feel better.

Standing _____ Sitting _____ Walking _____ Deep Breathing _____

Twisting _____ Carrying _____ Laying Down _____ Lifting _____

Turning _____ Coughing _____ Sneezing _____ Rising from chair _____

Rising from bed _____ Other _____ Other _____

What do you do to provide relief? _____

_____

_____

5. Please describe how this condition is affecting:

Work: _____

Sleep: _____

Emotional State: _____

Functional Mobility *(walking, bed mobility, transfers, driving, etc)*

_____

_____

Activities of Daily Living /Self-Care:_____

_____

6. Are you taking any of the following? Circle all that apply

Aspirins Anti-depressants Diet Supplements Sleeping Pills Vitamins

Laxatives Insulin Sedatives Hormones Herbs

7. Please list any medication you are currently taking: _____

_____

Past Medical History

8. Have you ever been diagnosed with a heart condition, diabetes or cancer? If so, please describe: _____

_____

_____

_____

9. Please describe if you have experienced any of the following in addition to those previously mentioned:
Please include approximate dates when they occurred.

Broken bones _____

Vehicle accidents _____

Whiplash _____

Falling on tailbone _____

Other accidents _____

Major illnesses/ Immune disorders_____

_____

Surgical procedures* _____

** Please include tonsil removal, wisdom tooth removal, plastic surgery, breast augmentation, etc.*

Other Hospitalizations: _____

Dental History

Braces? Y / N How long? _____ What age?_____ **Root canals**? Y / N If so, how many? _____

Mercury Fillings? Y / N Were they removed? Y / N

Did you have chelation after they were removed? Y / N

Do you have: dentures, bridges, any other dental appliances? _____

Please help us be aware of any of the following precautions:

Are you pregnant? Y / N

Range of motion restrictions/ Activity limitations: _____

Implantation of medical or dental devices *(cardiovascular, catheters, medicine pumps, IUD, shunts, dentures, other)*:

_____

Swallowing/ Food precautions _____

Breathing/ suctioning _____

Positioning Issues _____

Latex Allergies _____

Is there any Concern regarding a change in Intracranial Pressure? Y / N

Other: _____

What are your goals for treatment? _____

_____

_____

If your current condition is related to a traumatic event or accident please complete the following below.
Please describe the significant details regarding how your injury/ accident / trauma occurred:

_____

_____

Was emergency care provided at the scene? Y / N

If not, when/ where did you seek medical care? _____

Was there a loss of consciousness at the time? Y / N How long were you unconscious / comatose? _____

Did you sustain a Spinal Cord Injury? Y / N

What level? _____

Is the Classification: Complete/ Incomplete Anterior Cord Central Cord Brown-Sequard

Other: _____

Closed Head Injury? Traumatic Brain Injury? _____

_____

Please list significant details regarding hospital stay:

How long were you in inpatient acute care? _____

Inpatient rehabilitation? _____

Was intubation/ ventilator required? _____

Did you have any broken bones? Y / N How were they stabilized? _____

Please list surgeries that were performed and when: _____

_____

Were you discharged home with home therapies or outpatient services? _____

_____

Are you currently receiving therapies?

PT:
_____

OT:
_____

Speech: _____

On the following page, please circle all symptoms you have difficulty with and note specific areas as appropriate.

Upledger Institute Clinic

Arthritis
Asthma
Anemia
Atrophy
Aneurysm
Bowel/Bladder issues
Blood Pressure
Low / High Balance problems
Cardiovascular disease
Constipation
Chest pain
Cold hands / feet
Cold sweats
Cognitive changes
Coordination/ Motor planning
Diarrhea
Dizziness
Developmental delays
Depression
Disc Bulge / Herniation
Edema / Swelling
Emotional Status
Face Flushed
Fainting
Fatigue
Grating in Neck
Gallbladder issues
Gas
Hearing
Heart pain or palpitations
Hay Fever
Head feels heavy
Hernia
Intestinal disorders
Immune deficiencies
Inner tension
Irritability
Loss of Smell
Loss of Taste sensations
Low Back or Sacroiliac Pain
Memory changes
Muscle Spasm / Cramping
Mood Swings
Muscle tone
Night sweats
Neuritis/ Neuralgia
Nervousness
Neuromuscular disease
Neurological trauma or disease
Neck Pain
Numbness
Nystagmus
Orientation to time, place, self
Oral - Motor dysfunction
Painful joints or extremities
Pinched nerves
Paralysis
Perspiration- excessive or diminished
Pins and Needles feeling
Rheumatism
Rib Pain
Sciatica
Sensory Integration Issues
Sensory Changes
Scoliosis
Sinus pain / infections
Speech/ Communication
Swallowing difficulties
Stress
Shortness of breath
Strabysmus (lazy eye/ eyes) crossing)
T.B.
Twitching
Tone Changes
Tremors
Ulcers
Vertigo
Vestibular dysfunction
Visual deficits / sensitivities