One of your requirements for CBCN certification is preparing two (2) PUBLISHABLE case histories.

Each case history must consist of two parts:

1) A complete case history covering everything as itemized on the Grading sheet, including rationale and documentation to demonstrate that you are an expert in nutrition;

2) A publishable case history in a narrative format that includes a title, keywords, abstract, body, and references. The following link will give you an outline order of what is expected for a publishable case history: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2597880/

There is a great deal of confusion about what this means. We will have an example of a publishable case history on our website. This should be a document that other doctors who are not as well trained in nutrition can read and understand and learn from.

You have learned a great deal in your 300-hour program, including some terrific tools to help treat your patients. However, the purpose of preparing these case histories is to demonstrate YOUR knowledge and thought process from beginning to end of the case. Using some of these tools in these specific cases will help demonstrate that you are an expert in the field of nutrition.

The case history must include a complete description of the patient’s chief complaint gleaned from your consultation, not simply based on what the patient states on your forms. Other complaints should be documented similarly.

Our guidelines for grading (see guidelines) provide a specific list of items that should be included in your case history, but it is not intended to be a fill-in the blank form.

Your report should be separated into clearly demarcated sections describing the history, exam findings, significant test results and how you arrived at your conclusion (diagnosis), what you recommended (tests, dietary changes and supplements), why and what the results were.

Your case history should be succinctly and intelligently written. 25% of your grade will be based on how publishable your case history is.

In addition, your final report should include an addendum complete with documentation which should include your consultation notes, examination results, and diagnostic test results. But please don’t include pages and pages of blood tests that we have to sift through. If you have serial blood tests, we recommend putting them in a spreadsheet so we can see the progression of the case easily.

Finally, once complete, scan your case history and all documentation (you can take it Kinko’s or Staples to scan it) and email the file to CBCN.us@gmail.com.