Wellness History Report

Date: _____

Referred By:_____

Name: _____

Street: _____City: _____State: ____ Zip Code: _____

Home Ph.:(____) _____ - _____Cell Ph.: (____) _____ - _____E-mail: _____

Emergency Contact: _____ Phone: (____) _____ - _____

Date of Birth: ___/___/___ Marital Status: Single ___ Separated ___ Divorced ___ Married ___ Widowed ___

SS# _____ Number of Children: _____

Occupation: _____Employer: _____Bus. Ph. (____) _____ - _____

When was your last Medical care: ____/____/____ Dr's Name & Ph. # _____

When was your last Chiropractic care: ____/____/____ Dr's Name & Ph. # _____

When was your last Dental care: ____/____/____ Dr's Name & Ph. # _____

Date of last Physical Exam: ____/____/____ Diagnosis/Condition _____

Date of last Blood Test: ____/____/____ Diagnosis/Condition _____

Date of last Urine Test: ____/____/____ Diagnosis/Condition _____

Date of last Spinal X-ray/MRI: ____/____/____ Diagnosis/Condition _____

What is your major complaint? _____

How long have you had this condition? _____ Getting worse? _____ Constant? _____

What caused the problem to occur? _____

Pain comes/goes? _____ What aggravates it? _____ Similar condition in past? _____

Is the pain __Constant __Intermittent __Sharp __Dull __Achy __Throbbing __Stiff?

Does the pain radiate? ____ If yes, where? _____

List previous diagnosis/treatments you have received for this condition _____

What do you believe is wrong with you? _____

Other complaints? _____

Have you been in an auto accident in the past year? _____ 5 years? _____ Ever? _____

Have you ever been diagnosed with an autoimmune disorder? _____ If yes, describe: _____

Have you ever had any immune problems? _____ If yes, describe: _____

What is your sleeping trend? (How many hours?) _____ __uninterrupted__interrupted

How many bowel movements do you have per day? _____ What is their consistency? _____

How many ounces of "pure water" do you drink per day? _____Ounces.

Do you drink cold or room temperature water? _____

Is it __tap water__well water __bottled water __filtered water __reverse osmosis water __distilled water?

Are you vegetarian? __Yes __No Are you vegan? __Yes __No

Have you tried a specific diet? __Yes __No If yes, which one? _____

Do you wear contact or other prosthesis? _____ If Yes, what kind? _____

Have you ever received a massage before? _____ If yes, what type? _____

What is your dominant emotion?

__Impatience __Worry __Depression/Guilt __Fear/Frustration __Anger

__Love __Content __Courage/Compassion __Gentleness/Confidence __Kindness

__Other _____

Please list all your current:

Medications:

1)_____ Reason for taking it: _____ Since when: _____
2)_____ Reason for taking it: _____ Since when: _____
3)_____ Reason for taking it: _____ Since when: _____
4)_____ Reason for taking it: _____ Since when: _____
5)_____ Reason for taking it: _____ Since when: _____
6)_____ Reason for taking it: _____ Since when: _____
7)_____ Reason for taking it: _____ Since when: _____
8)_____ Reason for taking it: _____ Since when: _____

Over the counter Medications:

1) _____ Reason for taking it: _____ How often: _____
2) _____ Reason for taking it: _____ How often: _____
3) _____ Reason for taking it: _____ How often: _____
4) _____ Reason for taking it: _____ How often: _____
5) _____ Reason for taking it: _____ How often: _____

Nutritional Supplements, Herbs, Herbal preparations or Homeopathic preparations:

1) _____ Since When: _____
2)_____ Since When: _____
3)_____ Since When: _____
4)_____ Since When: _____
5)_____ Since When: _____

Any Allergies/Bad Reactions to Medications and/or Food?

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Are you allergic to Latex (i.e. Rubber gloves)? _____

Do you have a history of antibiotic therapy? _____

If yes, how many times within the last year? _____ 5 Years? _____ Ever? _____

Please answer all the questions. When you answer yes, please give details.

Health History	Yes	No	If "Yes", Give Details
Have you had any Surgeries or Operations:			
Back, Neck, Arm, Hand, Leg, Foot, etc.			
Dental Surgery			
Childbirth			
Any other surgeries (i.e. hernia, heart, veins, etc.)			
Ever been hospitalized other than surgery			
Skin: Have you ever had or do you currently have:			
Hives, Eczema or Rash			
Chronic Skin Problems (i.e. Cuts slow to heal)			
Excessive Skin Dryness			
Problems with "Easy" Bruising			
Chemical or Jewelry Rash/Sensitivity			
Chicken Pox and/or Shingles			
Measles			
Lymphoma/Melanoma			
Herpes			

Health History Continued	Yes	No	If "Yes", Give Details
Neuro – Have you ever had or do you currently have:			
Do you snore?			
Are You Tired After You Sleep?			
Do You Nod off During The Day?			
A Psychiatric or Emotional Problem			
Numbness/Weakness/Paralysis/Clumsiness			
Dizziness or Fainting Spells			
Severe or Frequent Migraine Headaches			
Head Injury, Concussion or Skull Fracture			
Neurological Disorders			
Seizures, Blackouts or Epilepsy			
Stroke			
Have you ever been knocked unconscious?			
Temporary loss of understanding			
Sudden collapse without loss of consciousness			
Slurred speech or other speech problems			
Nervous tension and/or panic attack			
Neuralgia			
Ear/Eye - Have you ever had or do you currently have:			
Hearing Loss in one or both ears			
Frequent Ear Infections or Ear Discharge			
Ringing, buzzing or any noise in one or both ears			
Other Ear Problems			
Glaucoma or Cataracts			
Red Eyes and/or Pink Eyes			
Eye Injury/Vision Loss			
Other Eye Problems (such as blurred vision)			
Glasses/Contacts/Laser Surgery			
Date of Last Vision Screen: _____			
Do you have a hard time seeing at night?			
Head/Neck - Have you ever had or do you currently have:			
Date of Last Dental X-ray: _____			
Recent Problems With Teeth/Dentures			
Any Wisdom Teeth Removed?			
Any Amalgam Fillings? How Many?			
Any Recent Removal of Amalgam Fillings?			
Any Root Canals? How Many?			
Frequent Mouth Ulcers/Infections			
Sinus Infections or Hay Fever			
Loss of smell and/or taste			
Frequent Sore Throats or Strep Throat			
Difficulty Swallowing?			
Any History of Mumps or Mononucleosis			
Frequent Nose Bleeds and/or Colds			
Nasal Obstruction			
Trouble With Thyroid (i.e. Taking Thyroid Medication)			
Goiter			
Problem Requiring Radiation Treatment To The Neck Area			
Lungs— Have you ever had or do you currently have:			
Asthma or Wheezing			
Coughed Up Any Blood and/or Phlegm			
Bothered By Shortness of Breath Without Apparent Reason			
Tuberculosis or A Positive Skin Test For Tuberculosis			
Pneumonia or Pleurisy			
Emphysema			
Cough Every Day, Especially In The Morning			
Pain or Tightness In Chest			
More Than Three Episodes of Bronchitis In One Year			
Date of Last Chest X-ray:			

Health History Continued	Yes	No	If "Yes", Give Details
Heart - Have you ever had or do you currently have:			
Heart Murmur or Rheumatic Fever			
Heart Disease			
Chest Pain With Activity			
Treated For Heart Condition			
Unusually Cold or Bluish Colored Hands and/or Feet			
High Blood Pressure—If "Yes" How Is It Treated?			__Medicine __Diet __Exercise:_____
Low Blood Pressure			
Do You Have A History of Elevated Cholesterol			
Anemia or Any Blood Disease			
Phlebitis, Varicose Veins or Blood Clots/Poor Circulation			
Arteriosclerosis (Hardening of Arteries)			
Pacemaker			
Pain Over the Heart			
Rapid Heart Beat or Slow Heart Beat			
Aneurysm			
Artificial Valves or Mitral Valve Prolapse			
Swelling of the Ankles			
Congenital Heart Defect			
GI - Have you ever had or do you currently have:			
Ulcers, Indigestion, Pain or Burning In Stomach			
Hiatal Hernia/GERD/Acid Reflux			
Belching			
Vomiting of Blood			
Appendicitis			
Constipation			
Abdominal Pain			
Distension of the Abdomen, Bloating, Flatulence			
Hemorrhoids			
Blood/Tarry Bowel Movements			
Infectious Diarrhea (e.g. Salmonella)			
Frequent Loose Bowel Movements			
Colitis or Nervous Stomach			
Yellow Jaundice or Hepatitis			
Metallic or Bitter Taste			
Problems With Your Pancreas (Diabetes,Hypoglycemia,etc,)			
Gallbladder Disease			
Hernia			
Kidneys - Have you ever had or do you currently have:			
Bladder or Kidney Infections			
Kidney Stones			
Burning, Discomfort on Urination or Frequent Urination			
Blood In Urine			
Incontinence (Inability to Control Bladder)			
Bed-wetting			
Miscellaneous - Have you ever had or do you currently have:			
Cancer of Any Kind			
AIDS-HIV			
Gout			
Multiple Sclerosis			
Lupus			
Rheumatoid Arthritis			
Fibromyalgia			
Chronic Fatigue			
Polio			
Malaria			
Typhoid Fever			
Venereal Disease (STD's)			
Other			

Health History Continued	Yes	No	If "Yes", Give Details
Musculo-Skeletal - Have you ever had or do you currently have:			
Arthritis or Rheumatism			
Been Treated For A Neck or Back Problem			
Recurrent Back Pain, Sciatica, Disc Problems			
Bursitis, Tendonitis			
Any Broken Bones			
Recurrent Pulled Muscles or Sprains			
Any Hand or Wrist Injury or Problem			
Any Joint Problems with or without Swelling			
Any Foot or Ankle Injury or Problems			
Job Requiring Heavy Lifting or Standing, or Sitting for Long Periods of Time			
Pain Between the Shoulder Blades			
Any Numbness and/or Pins & Needles Experienced			
Any Cramps in Legs at Night			
Any Restless Legs at Times			
Are You Wearing Shoe Lifts, Inner Soles or Arch Supports?			
Have You Had Any Illness or Injury That We Have Not Asked About?			
General Lifestyle: Check the Answer That Best Describes You.			
Use of Recreational Drugs per Week			__ 0 __ 1-5 __ 6-10 __ 11-16
Use of Alcoholic Beverages per Week			__ 0 __ 1-5 __ 6-10 __ 11-16
Use of Soft Drinks Beverages per Week (Diet/Regular)			__ 0 __ 1-5 __ 6-10 __ 11-16
Cups Coffee or Black Tea per Week			__ 0 __ 1-5 __ 6-10 __ 11-16
Glasses of Sweetened Ice Tea per Week			__ 0 __ 1-5 __ 6-10 __ 11-16
Glasses of Milk per Week			__ 0 __ 1-5 __ 6-10 __ 11-16
Ever Needed an "eye-opener" (a drink in the morning)?			
Have you ever used tobacco in any form?			How long___ yrs. Pack/Day___ When Quit
Do You Exercise 3 Times Per Week? 30-40 Min. Each Time			Identify Types If Yes
Are You More Than 20 lbs. Above Your Ideal Weight?			
Have You Ever Been Immunized?			Year immunized:
Work History - Have You EVER:			
Been Restricted In Your Work or Given "Light Duty" Because of Your Health or Injury			
Left A Job Because of Health Problems			
Been Injured On The Job And Treated By A Doctor			
Are You Receiving Any Health Care Treatment (i.e. Physical Therapy, Chiropractic, Acupuncture, Medical, Etc.)			
Any Work Hazards or Chemical Exposures			
FOR FEMALES ONLY - Have you ever had or do you currently have:			
Menstrual Irregularities			
Congested Breasts			
Breast Masses or Lumps			
Painful Menstruation			
Excessive Menstrual Flow			
Vaginal Discharge/Vaginal Dryness			
Currently Using Birth Control Pills?			How Long: _____
Currently Using IUD Control Device?			How Long: _____
Currently Taking Hormone Replacement Therapy?			
Hot Flashes			
Menopausal Symptoms			
Low Sex Drive			
Breast Reduction or Augmentation			
Previous Miscarriages			
Are you Pregnant? If Yes, How many months?			
Date of Last Cycle: _____/_____/_____			

Health History Continued	Yes	No	If "Yes", Give Details
FOR MALES ONLY - Have you ever had or do you currently have:			
Prostate Problems			
Breast Tenderness, Swelling or Lumps			
Pain or Burning with Urination			
Difficulty Urinating or Dribbling			
Penile or Testicular Problems			
Abnormal Penile Discharge			
Erectile Dysfunction			
Low Sex Drive			

The questions below are about your Birth Parents, Brothers and Sisters.

	Mother	Father	Brothers/Sisters
Age if Alive			
Age and Cause of Death			

Do/Did your birth parents, brothers or sisters have any of the following illnesses or events?
If no, check box. If yes, list age illness began or event occurred.

	Yes	No	Mother	Father	Brothers/Sisters
Heart Attack/Heart Surgery					
Heart Disease					
Stroke					
High Blood Pressure					
High Cholesterol					
Diabetes					
Obesity (Very Overweight)					
Asthma					
Cancer					
Kidney or Liver Problems					
Lung Problems					
Tuberculosis (TB)					
Psychiatric Problems					
Alcohol/Drug Problems					
Inherited Diseases					
Other					

* Before accepting you as a Patient, the Doctor will evaluate your history, physical examination findings and laboratory reports to assure that we have the best treatment choice for this condition.
* Our policy requires payment in full for all services rendered at the time of visit.
* I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
* I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____