# Wellness History Report

**Date:** _____

**Referred By:**_____

Name: _____ Age: _____

Street: _____City: _____State: ____ Zip Code: _____

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

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

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

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. Current weight: _____

Do you drink cold or room temperature water? _____

Is it ☐ tap ☐ well ☐ bottled ☐ filtered ☐ reverse osmosis ☐ distilled?

Are you vegetarian? _____ Are you vegan? _____

Have you tried a specific diet? _____ 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 now 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? | | | |
| **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 | | | | | |

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- 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. I am responsible for paying for any appointment cancellation of less than 12 hours.

Signature: _____ Date: _____