

Health & Wellness History

Name: _____ Date: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____ Sex: M F Age: _____ Birth date: _____ Marital Status: S M W D

Employer: _____ Occupation: _____ Work Status: FT PT

How did you hear about our office? _____

Briefly describe your problem: _____

How do you view your problem? (check one):

MINIMAL (annoying but causing NO limitations)

SLIGHT (tolerable but causing a little limitation)

MODERATE (tolerable but causing limitations)

SEVERE (causing significant limitations)

Since your problem became this severe, what three things have you missed out on the most?

1. _____

2. _____

3. _____

What changes/modifications have you had to make in your lifestyle due to your problems?

Do you believe your problem is getting worse over time? _____

Currently Care Under? M.D. _____ D.C. _____

Other: _____

Recent Physical Exams: _____ Date: _____

Lab Work: _____ Where/When: _____

X-Rays, MRI, CT: _____ Where/When: _____

Stress Test: _____ Where/When: _____

Other: _____

(Office Use)

| | | |
|--------------|-----------|---------------|
| Ht: _____ | Wt: _____ | Blood: _____ |
| BP: _____ | O2: _____ | Hair: _____ |
| Pulse: _____ | | Report: _____ |

Name: _____ Date: _____

PLEASE CHECK THE FOLLOWING THAT APPLY TO YOU:

Digestive Track

- nausea & vomiting
- diarrhea
- constipation
- bloated feeling
- stomach pains or cramps
- heart burn
- blood and/or mucous in stools

Ears

- itchy ears
- ear aches/ear infections
- drainage from ear
- ringing in ears
- hearing loss
- reddening of ears

Emotions

- mood swings
- anxiety/fear/nervousness
- anger/irritability/aggressiveness
- argumentative
- frustrated/cries easily
- depression

Eyes

- watery or itchy eyes
- red/swollen/itchy eyelids
- bags or dark circles under eyes
- blurred or tunnel vision

Head

- headaches
- faintness
- dizziness
- insomnia/sleep disorder
- facial flushing

Heart

- irregular/skipped heartbeat
- rapid/pounding heartbeat
- chest pain

Genitourinary

- kidney
- urinary tract
- bladder
- yeast infections

Joints & Muscles

- pains/aches in joints
- arthritis/osteoarthritis
- stiffness/limited movement
- pain/aches in muscles
- feeling weak/tired
- swollen/tender joints
- growing pains in legs
- psoriatic/gouty arthritis

Lungs

- chest congestion
- asthma/bronchitis
- shortness of breath
- difficulty breathing
- persistent cough
- wheezing

Mind

- poor memory
- difficulty completing projects
- difficulty with mathematics
- underachiever
- poor/short attention span
- confusion
- easily distracted
- difficulty making decisions
- learning disabilities

Mouth & Throat Thrush

- chronic coughing
- gagging/clearing throat often
- sore throat/hoarse voice/voice loss
- swollen/discolored tongue/lips
- canker sores
- itching on roof of mouth

Nose

- stuffy nose
- chronically red/inflamed nose
- sinus problems
- hay fever
- sneezing attacks
- excessive mucous formation

Skin

- acne
- itching
- hives/rash/dry skin
- hair loss
- flushing/hot flashes

Weight

- binge eating/drinking
- craving certain foods
- excessive weight
- compulsive eating
- water retention

Other

- frequent illness
- frequent/urgent urination
- genital itch/discharge
- anal itching

Other Symptoms

Other Health Conditions:

Name: _____ Date: _____

Medications

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

| <u>DRUG</u> | <u>PRESCRIBED FOR:</u> | <u>HOW LONG</u> |
|-------------|------------------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list all drugs taken within the last year including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

| <u>DRUG</u> | <u>PRESCRIBED FOR:</u> | <u>HOW LONG</u> |
|-------------|------------------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.

| <u>VITAMINS</u> | <u>HOW MUCH</u> | <u>BRAND</u> |
|-----------------|-----------------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

