PATIENT HEALTH HISTORY

Re-evaluation: [ ] Yes

1. Name:_____ Gender: [ ]M, [ ]F Age:____ DOB:_____ Height:_____ Weight:____
   Address:_____
   Phone:_____ E-mail:_____ Birthday:_____
   Primary Physician:_____Phone_____ Fax:_____
   Primary Physician's Email: _____

2. Have you ever used: [ ] Chiropractic Treatment [ ]Chinese Herbal Medicine [ ]Acupuncture [ ]Homeopathy
   If yes, for which conditions? _____
   If no, would you like to hear about options for your condition (please circle)? Yes No

3. What is the reason for your visit? What is your chief complaint? (Describe your condition at its worst)

   _____

   _____

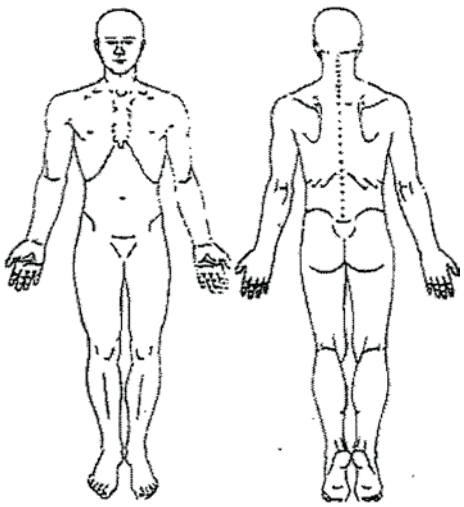
   Other Complaints:_____
   Diagnosed Medical Conditions: _____

4. Cause of Health Conditions: [ ] Injury [ ] Auto Accident [ ] Personal Injury [ ] Other:_____
   Has the accident been reported? Yes No Reported to: [ ]Employer [ ]Auto Carrier [ ]Other: _____
   Are you now or have you ever been disabled? Yes No Date:_____ Cause: _____
   Have you ever retained an attorney? Yes No Name:_____ Phone: _____

5. Pain Symptoms: a._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
   (In Order b._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
   of Severity) c._____ Began (Mo/Yr)_____ Previous Episodes (Mo/Yr)_____

6. Please circle areas of pain or discomfort and mark them using the codes listed below:
   N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars
   List the frequency and severity of your condition on a scale of 1 to 5:

Frequency:	Severity:
1=20% of the time	1=Annoying
2=40% of the time	2=Impairment to Activity
3=60% of the time	3=Need Medication
4=80% of the time	4=Impairment with Medication
5=100% of the time	5=Severe (Need Hospitalization)



Location	Frequency	Severity	Initial Cause	Getting Worse?
a.				Yes No
b.				Yes No
c.				Yes No

Does it affect other areas of your body (please circle)? Yes No
If yes, explain: _____

7. Do you have, or have you ever had:

Osteoarthritis_____	Joint Separations_____	Non-union Fracture_____	Cartilage injury_____
Bone Spurs_____	DDD_____	Avascular Necrosis_____	(Meniscus Tear, Chon-
Bulging Disc_____	Bursitis_____	Post-herpetic neuralgia___	dromalacia Patellar Syn-
Tendonitis_____	Stenosis_____	Intercostal Neuralgia_____	drome)
Herniated Disc_____	Sprains_____	Morton's Neuroma_____	

8. Does the condition interfere with (please circle): Work Sleep Other:_____
   Please describe:_____
   Without treatment, how would it affect your quality of life? _____

   _____

9. What seems to make the condition better? _____
   What seems to make it worse? _____
   What treatments have you tried? _____

10. If you are currently under the care of a health care practitioner for any conditions or injuries, please provide their:
    Name: _____ Phone: _____ Email: _____
    Description of Treatment: _____

11. Please list any current therapies: _____

12. Please describe your family health history:

	You	Father	Mother	Spouse	Brothers		Sisters		Children	
Age										
Arthritis										
Acid Reflux or Stomach Problems										
Allergy and Food Allergy										
Asthma or Hav Fever										
Back or Disc Problems										
Bursitis										
Cancer										
Constipation										
Emotion Problem										
Epilepsy										
Headaches or Migraines										
Heart Problems										
High Blood Pressure										
Insomnia										
Kidney Problems										
Liver Problems										
Lung Problems										
Obesity										
Scoliosis										
Sinus Problems										
Other: _____										

13. Please describe your lifestyle (please circle):

    Appetite: Low Moderate High
    Thirst for Water: Yes No Glasses/Day
    Coffee: Yes No Cups/Day
    Soda: Yes No Cups/Day
    Artificial Sweeteners: Yes No
    Cravings for Sugar: Yes No
    Cravings for Salty Foods: Yes No
    Stress Level: High Moderate Low
    Alcohol: Yes No Glasses/Day
    Smoking: Yes No Cigarettes/Day
    Marijuana: Yes No Times/Day
    Other Drugs : _____
    Occupational Hazards: _____

    Exercise (please circle):

    None Very Active

    Light Elite Athlete

    Moderate

    Active

    Type of Exercise: _____

    Frequency of Exercise: _____

14. List vitamins or supplements taken in the last 2 months: _____
    _____

15. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:
Anti-acids (please check): [ ] TUMS [ ] Zantac [ ] Other:_____
Proton Pump Inhibitors (please check): [ ] Prilosec [ ] Pepcid [ ] Prevacid [ ] Other: _____
Other Medications:_____
_____

16. Please describe your health history (please check).

Now	Past		Now	Past		Now	Past		Now	Past	
____	____	Acid Reflux/Heart Burn	____	____	Diverticulitis	____	____	Influenza	____	____	Pulmonary Fibrosis
____	____	AIDS/HIV	____	____	Drug Withdrawal	____	____	IBD	____	____	Rheumatic Fever
____	____	Alcoholism	____	____	Emphysema	____	____	IBS	____	____	Rheumatoid Arthritis
____	____	Allergies	____	____	Epilepsy	____	____	Kidney Stone	____	____	Sarcoidosis
____	____	Anemia	____	____	Eczema	____	____	Lyme Disease	____	____	Scarlet Fever
____	____	Appendicitis	____	____	Fatty Liver	____	____	Measles	____	____	Seizures
____	____	Arthritis	____	____	Fibromyalgia	____	____	Mental Disorder	____	____	Stroke
____	____	Arteriosclerosis	____	____	Fibroid	____	____	Migraines	____	____	Thyroid Disorders
____	____	Asthma	____	____	Gall Bladder Stone	____	____	Multiple Sclerosis	____	____	Tuberculosis
____	____	Birth Trauma	____	____	Goiter	____	____	Mump	____	____	Typhoid Fever
									____	____	Ulcers, Location: _____
____	____	Bronchiectasis	____	____	Gout	____	____	Ovarian Cyst			
____	____	Breast Lump	____	____	Hernia	____	____	Pacemaker	____	____	Ulcerative Colitis
____	____	Cancer	____	____	Heart Disease	____	____	Pancreatitis	____	____	Crohn's Disease
____	____	Chicken Pox	____	____	Heart Murmur	____	____	Pleurisy	____	____	UTI
____	____	Chronic Bronchitis	____	____	Hepatitis	____	____	Pneumonia	____	____	Interstitial Cystitis
____	____	Cirrhosis	____	____	Herpes	____	____	Prostatitis	____	____	Vitiligo
____	____	COPD	____	____	High Blood Pressure	____	____	Polio	____	____	Venereal Disease
____	____	Cystic Fibrosis	____	____	High Cholesterol	____	____	Psoriatic Arthritis	____	____	Whooping Cough
									____	____	Other, Describe _____
____	____	Diabetes	____	____	Hyperlipidemia	____	____	Psoriasis			

17. Please use the point scales to rate your symptoms over the past 3 months.

1 = Occasional, Not Severe

Digestive Tract
_____ Acid reflux/Heart Burn
_____ Poor Digestion
_____ Nausea & Vomiting
_____ Bloating
_____ Gas
_____ Hiccups
_____ Bad Breath
_____ Gluten Intolerance
_____ Food Allergies
_____ Chemical Sensitivities
_____ Malnutrition
_____ Difficulty Swallow
_____ Achalasia
_____ Diarrhea
_____ Constipation
_____ Laxative Use
_____ Blood in Stool
_____ Mucous in Stool
_____ Black Stool
_____ Stomach Pains/Cramps
_____ Abdominal Pain
_____ Abdominal Spasms
_____ Lack of Bowel Control
_____ Itchy Anus
_____ Rectal Pain
_____ Hemorrhoids
_____ Anal Fissures

2 = Occasional, Severe

_____ Bowel Movements:
Frequency _____
Color _____
Texture/Form _____
Odor _____

General
_____ Sweat Easily
_____ Night Sweats
_____ Gall Bladder Troubles
_____ Poor Circulation
_____ Shortness of Breath
_____ Spitting Blood
_____ Fever
_____ Chills
_____ Muscle Cramps
_____ Lower Extremity Edema
_____ Vertigo or Dizziness
_____ Bleed or Bruise Easily
_____ Frequent Illness
_____ Seasonal Allergy
_____ Addicted to Drugs
_____ Addicted to Smoking
_____ Peculiar Taste:
Describe: _____

3 = Frequent, Not Severe

Respiratory
_____ Tight Chest
_____ Shortness of Breath
_____ Difficulty Breathing When Lying Down
_____ Itching Inside the Chest
_____ Wheezing
_____ Persistent Cough
_____ Coughing Blood
_____ Cough: Wet/ Dry, Thick/ Thin
Color of Phlegm _____

Urinary
_____ Bed-wetting
_____ Blood in Urine
_____ Lack of Bladder Control
_____ Pain During Urination
_____ Frequent or Urgent Urination
_____ Incomplete Urination
_____ Wake to Urination
_____ Prostate Problem
_____ Genital Itch or Discharge
_____ Kidney Stone
_____ Kidney Failure
_____ Recurrent Bladder Infections
_____ Impotence
_____ Increased Libido

4= Frequent, Severe
_____ Decreased Libido
_____ Premature Ejaculation
_____ Nocturnal Emission

Weight & Eating
_____ Recent Weight Loss/Gain
_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Poor Appetite
_____ Heavy Appetite
_____ Strongly Like Cold Drinks
_____ Strongly Like Hot Drinks
_____ Water Retention

Musculoskeletal
_____ Muscle Pains
_____ Muscle Cramps
_____ Pains or Aches in Joints
_____ Stiffness/Limited Range of Motion Limited Use
_____ Pains or Aches in Muscles
_____ Feeling of Weakness/tiredness
_____ Swollen Tender Joints
_____ Growing Pains in Legs
_____ Hip Tightness/Coldness/Pain

_____ Rib Pain
_____ Neck/Shoulder Pain
_____ Upper Back Pain
_____ Back Pain
_____ Lower Back Pain
_____ Sciatic Pain

Cardiovascular
_____ Heart Murmur
_____ Heart Palpitations
_____ Irregular or Skipped Heartbeat
_____ Rapid or Pounding Heartbeat
_____ Chest Pain
_____ Shortness of Breath
_____ Difficulty Breathing
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Blood Clots
_____ Anemia
_____ Fainting

Emotions
_____ Mood Swings
_____ Anxious, Fear, Nervous
_____ Angry Irritable, Aggressive
_____ Easily Stressed
_____ Argumentative
_____ Frustrated, Cries Easily
_____ Depression
_____ Abuse Survivor
_____ Considered/Attempted Suicide
_____ Seeing a Therapist

Mind
_____ Poor Memory
_____ Difficulty Completing Projects
_____ Difficulty with Mathematics
_____ Underachiever
_____ Poor/Short Attention Span
_____ Confusion
_____ Easily Distracted
_____ Difficulty Making Decisions
_____ Learning Disability

Neurological
_____ Seizures
_____ Numbness
_____ Tics
_____ Foot Neuropathy

Energy & Activity
_____ Apathy, Lethargy
_____ Attention Deficit
_____ Attention Deficit
_____ Lack of Strength
_____ Body Heaviness
_____ Hyperactivity
_____ Restlessness
_____ Shortness of Breath
_____ Stuttering or Stammering
_____ Slurred Speech

Ears
_____ Itchy Ears
_____ Ear Aches, Ear Infections
_____ Drainage from Ears
_____ Hearing Loss
_____ Reddening of the Ears
_____ Ringing in the Ears
_____ Headaches
_____ Concussions

Nose
_____ Stuffy Nose
_____ Dryness Inside the Nose
_____ Chronically Red, Inflamed Nose
_____ Sinus Problem
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucous Formation
_____ Back Dripping
_____ Nose Bleeding

Eyes
_____ Glasses/Contacts
_____ Watery or Itchy Eyes
_____ Red, Swollen or Sticky Eyelids
_____ Bags/Dark Circle Under Eyes
_____ Poor Vision
_____ Blurred or Tunnel Vision
_____ Sensitive to Sunlight
_____ Eye Strain
_____ Eye Pain
_____ Red Eye
_____ Itchy Eyes
_____ Easily Fatigued
_____ Spots in Eyes
_____ Night Blindness
_____ Glaucoma
_____ Cataract

Head
_____ Headaches
_____ Migraines
_____ Faintness
_____ Dizziness
_____ Insomnia, Sleep Disorder
_____ Facial Flushing
_____ Facial Pain
_____ TMJ

Mouth & Throat
_____ Chronic Coughing
_____ Gagging, Often Clearing Throat
_____ Sore Throat, Hoarse, Voice Loss
_____ Swollen/Discolored Tongue/ Lips
_____ Sores on Lips or Tongue
_____ Canker Sores
_____ Itching on Roof of Mouth
_____ Dry Mouth
_____ Excessive Saliva
_____ Recurrent Sore Throat
_____ Excessive Phlegm
Color:_____
_____ Swollen Glands
_____ Lumps in Throat
_____ Enlarged Thyroid
_____ Teeth Problem
_____ Gum Problem
_____ Grinding Teeth

Skin &Hair
_____ Acne
_____ Itching
_____ Hives
_____ Rash
_____ Eczema
_____ Dry Skin
_____ Ulcerations
_____ Hair Loss
_____ Dandruff
_____ Flushing or Hot Flashes
_____ Change in Hair/Skin Texture
_____ Loss in Pigmentation
_____ Fungal Infections
_____ Scars

For Women Only:

Age Menstrual Cycle Began:_____
Length of Cycle (Day 1 - Day 1):
_____
Duration of Flow: _____
_____ Dark Color Flow
_____ Clots in Flow
_____ Excessive Flow
_____ Irregular Circle
_____ Painful Period
_____ Excessive Vaginal Discharge
_____ Menopause Symptoms
_____ Lump in Breast
_____ Vaginal Dryness
_____ Vaginal Sores
_____ Vaginal Odor
Vaginal Discharge Color:
_____
# of Pregnancies: _____
# of Live Births: _____
# of Premature Births:_____
Age at Menopause:_____
Date of Last PAP:_____
Date Last Period Began:
_____

Any Other Symptoms:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

18. Operations and Procedures

Date		Date		Date		
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus	Other:
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia	_____
_____	Gall Bladder	_____	Female Organs	_____	Thyroid	Date:
_____	Back Operation	_____	Rectal Surgery	_____	Stomach	_____

List and date any accidents or falls (please check):
[ ]Car_____ [ ]Recreation_____ [ ] Sports_____ [ ]School_____ [ ]Other_____
List any broken bones:_____
Have you ever had spinal taps or spinal injections (please circle)? Yes No Date:_____
Have you ever lost consciousness (please circle)? Yes No Why? _____
Have you ever had X-ray taken? Yes No Date:_____ By Whom? _____
For what ailment were these X-rays taken?_____
Do you suffer from any condition other than that for which you are now consulting us?_____

Which childhood illness or major difficulties did you experience?

How was your mother's pregnancy with you?

How was your birth?

How was your parents relationship with each other during your childhood?

How was your relationship with your mother?

How was your relationship with your father?

Were there others in your childhood who were important to you?

Do you have siblings? How was your relationship with them?

Do you spontaneously remember childhood incidents?

Did you suffer psychological trauma?

Did you suffer physical trauma?

How was your puberty?

How is your relationship with your parents and siblings today?

Do you have children? How do you see your relationship with them?

PERSONAL GOAL: What do you expect from this process??