

HealthWise Family Chiropractic: Acupuncture Patient Health History

Date: ____/____/____

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ SS# _____ Gender: M/F Marital status: S M D W

Occupation _____ Employed by: _____

Work Address _____ Work Phone _____

Email Address _____ Cell Phone _____

Emergency Contact: _____ Phone number: _____

Is it ok to contact you by: Email Cell Phone Home Phone Home Address

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to HealthWise Family Chiropractic for Acupuncture in order of importance below:

Condition

Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction)

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking

6. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Family History: (Check those applicable)

<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
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Age (if living)

_____	_____	_____	_____	_____	_____
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Health (G=Good, P=Poor)

_____	_____	_____	_____	_____	_____
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Cancer

_____	_____	_____	_____	_____	_____
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Diabetes

_____	_____	_____	_____	_____	_____
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Heart Disease

_____	_____	_____	_____	_____	_____
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High Blood Pressure

_____	_____	_____	_____	_____	_____
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Stroke

_____	_____	_____	_____	_____	_____
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Mental Illness

_____	_____	_____	_____	_____	_____
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Asthma/Hay fever/Hives

_____	_____	_____	_____	_____	_____
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Kidney Disease

_____	_____	_____	_____	_____	_____
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Age (at death)

_____	_____	_____	_____	_____	_____
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Cause of Death

_____	_____	_____	_____	_____	_____
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9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? ____/____ When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Depression

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Easy Bruising Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat**

(please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds
Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough
Pleurisy Asthma Tuberculosis Shortness of Breath

Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure
Stroke Palpitations/Fluttering Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn
Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow
Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow
Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles
Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 2. # of Days of Menses: _____ 3. Length of Cycle: _____

4. Birth Control Type: _____ 5. # of Pregnancies: _____ 6. # of Miscarriages: _____

7. # of Abortions: _____ 8. # of Live Births: _____

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Leg Pain Upper Back Pain

Mid Back Pain Low Back Pain Joint Pain (if so, where?): _____

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

29. **Lifestyle:**

How many meals do you typically eat per day? _____

Exercise routine: _____

Spiritual practice: _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Level of education completed: High School Bachelors Masters Doctorate Other

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Y N Explain: _____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Television habits: _____

Reading habits: _____

Interests and hobbies: _____

How did you hear about us? _____

Would you like to receive our email newsletter? _____