Community Chiropractic Wellness Center

Confidential Patient Health Record

Name: _____ Date: _____

Address: _____City/State/Zip_____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail: _____ Would you like to receive our Newsletter? Y N

Date of Birth: _____ Age: _____ Marital Status: S M W D How many children? __

Name of Spouse: _____ Work Phone: _____

Occupation: _____

Who referred you to this office? _____

If patient is a minor, I hereby give my consent and permission to treat:

Child's name: _____ Date: _____

Signature of Parent of Guardian _____ Relationship to patient_____

Please describe your major health concerns:

1. _____

2. _____

3. _____

4. _____

5. _____

If you feel ill, when did you last feel well? _____

What goals would you like to achieve while you are in our office? BE SPECIFIC! (I.e. not "better health," but "weight loss," "more energy" etc…).

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

Pertaining to the goals listed, what would you be willing to do, to achieve them:

_____

1. **Where did you grow up? _____**

2. **Have you traveled outside the US, including Mexico & Canada? (circle one) YES NO**
   How many times? _____

Place of trip	Date of trip	How long on the trip	Did you become ill?	During or After?	Medication taken

3. **Have you ever had parasites that you are aware of? (circle one) YES NO**

   If yes, what was done to resolve? _____

4. **Have you ever had food poisoning? (circle one) YES NO If yes, how resolved?**

   _____
   How many bowel movements do you have per day? 1 2 3 Formed Loose

5. **Approximately how many times have you used antibiotics from childhood to the present?**
   Please circle: 0 1 – 5 times 6 – 10 times More than 10
   Any long-term use? (E.g. acne, prolonged illness or use in a hospital) YES NO

   What was the reason for the long-term use of antibiotics? _____

   _____

6. **Have you used or are your using prescription medications? (circle one) YES NO**
   Please list the prescription medications that you have taken as well as any recreational drug use:

Name of Drug	Reason for taking	Start and end date taken	Still taking?	Side affects that you know of?

7. **Do you use Tylenol, Ibuprofen, aspirin or other pain medications? (Circle one) YES NO Have you used them in the past? (Circle one) YES NO**

Name of Medication	How often do you take it?	How much do you take when you take it?
Tylenol		
Ibuprofen		
Aspirin		
Motrin		

8. **Do you drink or did you drink in the past: diet soda or use artificial sweeteners?(circle one) YES NO**

Name of Beverage/sweetener	Are you still drinking diet beverages or using artificial sweeteners?	How many an average month?

9. **Do you have mold allergies/exposure that you know of? (circle one) YES NO**

10. **Do you have any chronic or recurring concerns that never fully go away? (circle one) YES NO**

What is your concern(s)?	How long have you had this concern?	Why is it a concern for you?	Have you consulted anyone about your concern?

11. Hormone use: Do you use any of the following:

Name of Hormone	If you stopped how long did your take it?	If you are taking it how long have you been taking it?	Any side affects that you know of?
Cortisone			
Prednixone			
Thyroid			
Progesterone			
Estrogen			
Birth Control Pills			

12. Vaccinations/flu shots: Did you have any of the following:

Name of Vaccination	Date(s) that you had it?	Any reactions that you know of?	Did you get sick after the vaccination?	How long after the vaccination did you get sick?
Flu shot				
Polio				
DPT				
Tetanus				
Hepatitis B				
MMR				

13. Teeth:

Do you have any fillings?	YES	NO	Approximately how many?___		
What materials were used?	Silver/Mercury	Gold	Plastic	Porcelain	
Do you have any root canal(s)?	YES	NO	Approximately how many?___		
Do you have any crown(s)?	YES	NO	Approximately how many?___		
What materials were used?	Gold		Porcelain		
Do you have any tooth sensitivities?	YES	NO	Cold	Hot	Touch

14. Sleep/Energy:

Do you have energy throughout your day?	**YES**	**NO**
Do you need coffee, tea or other caffeinated beverage to keep you going?	**YES**	**NO**
Do you need to sleep more than eight hours a night?	**YES**	**NO**
I wake up	**Refreshed**	**Tired**
General mood: This is attributed to:	**X**	**X**

15. Pesticides/chemicals:

Have you had exposure to pesticides?	**YES**	**NO**
Do you use pesticide strips?	**YES**	**NO**
Do you spray for insects with Raid or a similar product?	**YES**	**NO**
Do you have or have you had a termite problem?	**YES**	**NO**
Have you sprayed for termites?	**YES**	**NO**
Do you use them on your garden lawn?	**YES**	**NO**
Did you grow up near or on a farm?	**YES**	**NO**
Have you lived near a public school or park?	**YES**	**NO**
Do you live near a public school or park now?	**YES**	**NO**
Were you exposed to pesticides during your childhood?	**YES**	**NO**

If YES, please describe the circumstances of your exposure:

_____

_____

Does your work expose you to chemicals? (E.g. paints, glues, white-out, copying, etc…)	**YES**	**NO**
Do you use many products containing chemicals in your home?	**YES**	**NO**
Do you have chemical sensitivities?	**YES**	**NO**

If yes, please describe:

_____

Do you color your hair? How often? _____	**YES**	**NO**
Do you have any tattoos?	**YES**	**NO**

How long have you had them? _____How many? _____Where on your body?

_____

Have you remodeled your home in the last 5 /10/15 years?	**YES**	**NO**
Has new carpeting been put in your home? When? _____	**YES**	**NO**
Painting done? New furniture? When? _____	**YES**	**NO**

16. Electromagnetic/ EMF: Do you live near high power lines?	**YES**	**NO**
Do you work near them?	**YES**	**NO**
Do you live/work near microwave antennas?	**YES**	**NO**
Do you use florescent lights in your home/work?	**YES**	**NO**
How many hours per day do you spend at a computer? _____	**YES**	**NO**
Does the computer have a flat screen monitor?	**YES**	**NO**
Do you use an electric blanket?	**YES**	**NO**
Do you use a hair dryer?	**YES**	**NO**
Do you sleep with an alarm clock within 3 feet of your head?	**YES**	**NO**
Do you use a cell phone?	**YES**	**NO**

17. For <u>Women</u> only:

Have you ever taken birth control pills? How long? _____	**YES**	**NO**

Are you currently using birth control pills? What kind? YES NO
What kind? _____
What side effects (if you know of any) did you experience from taking birth control pills? _____

Are you doing Hormone Replacement Therapy or did you do it in the past? YES NO
What kind of HRT? _____

How long have you been doing it or did you do it? _____

If you stopped doing it, when did you stop? _____

Length of cycle in days? 24 25 26 276 28 29 OTHER_____

Are you presently prone to yeast infections? YES NO
Were you in the past? YES NO

Menstrual period: Heavy Light How many days? _____

Fibrocystic breast tissue? YES NO

Have you had a mammogram? YES NO
What was the date of your last mammogram? _____
Where did you have it done? (hospital, clinic etc…) _____
How often do you have them? _____

Have you had a breast thermography? YES NO
What was the date of your last thermography? _____
Where did you have it done? (hospital, clinic etc…) _____
How often do you have them? _____

Uterine Fibroids? YES NO

Circle any of the following symptoms that you experience before during or after your period:

	BEFORE	DURING	AFTER
Cramps			
Bloating			
Back pain			
Headache			
Swelling			
Emotional changes			
Bowel changes			
Sleeping difficulties			
Fatigue			

18. Are all your body parts your own? YES NO
Knee/Hip replacement? YES NO
Metal/Surgical/Breast implants? YES NO
Transplants? YES NO